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The *Canadian Charter of Rights and Freedoms* and Access to Publicly Funded Health Care

by

Nola Maria Ries

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Laws.

Faculty of Law

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Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **"The *Canadian Charter of Rights and Freedoms* and Access to Publicly Funded Health Care"** submitted by **Nola Maria Ries** in partial fulfillment of the requirements for the degree of **Master of Laws**

Timothy Caulfield

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Sept 10/03

Abstract

This paper focuses on the application of the *Canadian Charter of Rights and Freedoms* in the health care context with particular attention to the claim that individuals have constitutionally-protected rights to publicly funded health care services. The *Charter* has been part of the Canadian legal landscape for over 20 years, but its application in many areas of governmental action – especially public benefit programs such as health care – is the topic of much debate and development. This paper analyses three issues: (1) whether section 7 of the *Charter* imposes a positive obligation on governments to provide a comprehensive system of health care insurance; (2) how notions of medical necessity and human dignity play out in the context of section 15 *Charter* claims regarding access to health care services; and (3) the role of cost arguments in justifying government decisions not to fund specific health care services under section 1 of the *Charter*.

DEDICATION

I dedicate this paper to the ones I love most:
Mom, Dad, Seán, Mr. Bun & Susie.
Special thanks to the last three for tolerating my absence.

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I wish to acknowledge the extraordinary support and encouragement from my thesis supervisor, Professor Timothy Caulfield. I also acknowledge the helpful comments of Professor Barbara Billingsley regarding Chapter Four of this paper.

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Chapter One: Introduction

My concern in this paper is with the application of the *Canadian Charter of Rights and Freedoms*[1] in the health care context. In particular, I focus on the claim that individuals have constitutionally-protected rights under sections 7 and 15 of the *Charter* to state-funded health care services. The *Charter* has now been part of the Canadian legal landscape for 20 years, but its application in many areas of governmental action – especially public benefit programs such as health care – is the topic of much debate and development. Similarly, our national system of public health insurance, which we know as Medicare, has existed since the 1960s, but its origins were rooted in conflict and compromise[2] and its future will surely follow a similar course.

Access to a system of universal, publicly funded health care is often described as a fundamental value for Canadians. Indeed, in its recent report, the Romanow Commission on the Future of Health Care in Canada stated Canadians believe access to medically necessary health care services is a "right of citizenship."[3] As medical sciences advance and public expectations for health care services grow, governments will undoubtedly face demands to fund an increasing array of services. However, public resources for health

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[1] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].

[2] See e.g. Christopher David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Kingston: McGill-Queen's University Press, 1986) and Malcolm Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and Their Outcomes* (Montreal: McGill-Queen's University Press, 1988).

[3] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy J. Romanow, Q.C.), online: Commission on the Future of Health Care in Canada <http:www.heatlhcarecommission.ca> at xvi [Romanow Report].

care are finite, so it is inevitable governments will not fund all conceivable treatments or therapies, even if those services may offer some benefit to some people.

Consequently, a key challenge facing our health care system is the question of defining what services ought to be publicly funded – what is in the "Medicare basket" and what is out. However, in deciding not to fund certain services, governments increasingly face the prospect of a *Charter* challenge in which claimants assert a breach of their rights under ss. 7 and 15(1). These provisions state:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

These rights are not absolute and infringements of them may be justified under s. 1 of the *Charter*, which states:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

A wide range of complex legal issues arises in the context of *Charter* claims in which litigants seek access to state-funded health care services, including fundamental questions about the scope of *Charter* rights, the policy-making authority of governments and the role of courts in scrutinizing allocation of scarce public resources. Working on a small part of this larger legal puzzle, I have structured this paper as follows. First, in Chapter Two, I discuss the notion of a "right to health care." My goal in this overview chapter is

to set the stage for the substantive chapters of this paper and my purpose is not to argue for or against the proposition that individuals have a legally enforceable right to health care. Rather, I review common arguments that philosophers, ethicists and lawyers often advance to deny or assert the existence of a right to health care.

Chapter Three, my first substantive chapter, examines the argument that s. 7 of the *Charter* encompasses a right to access publicly funded health care services. I trace an evolution in the types of claims made under s. 7 in regard to health care. The first cases I discuss assert classical, negative conceptions of rights – the freedom to make health care decisions without unwarranted state intrusion – and the second group of cases focuses on positive claims in which litigants ask courts to compel governments to provide specific health care services. I examine whether the Supreme Court of Canada is likely to interpret s. 7 as conferring a right to publicly funded health care and comment on the value of s. 7 litigation as a means to bring about health care reform.

Next, in Chapter Four, I turn to s. 15 of the *Charter* and consider the very complicated question of determining when a denial of public funding for a health care service constitutes discrimination. I narrow my focus in this chapter to two elements that bring considerable ambiguity into s. 15 claims in which individuals seek government funded health care: (1) the vagueness of the term "medically necessary", which is used in the *Canada Health Act*[4] and provincial health insurance statutes to describe the services that fall into the Medicare basket; and (2) the ambiguous notion of human dignity, which the Supreme Court has described as the core interest protected by s. 15. With reference to

[4] R.S.C. 1985, c. C-6.

two key legal decisions – *Cameron v. Nova Scotia*[5] and *Auton v. British Columbia*[6] – I assess how litigants and courts interpret and use the terms "medically necessary" and "human dignity."

In Chapter Five, my last substantive chapter, I turn to the role of s. 1 of the *Charter* in justifying government decisions not to fund particular health care services. Specifically, I examine the role of cost arguments and the principle of judicial deference in the s. 1 justification analysis. I suggest that if governments want to make a credible argument that judges should be cautious in interfering with resource allocation choices, their decision-making processes must be worthy of deference.

Finally, in Chapter Six, my concluding chapter, I briefly discuss the phenomenon referred to as the "judicialization of politics", the process of using legal action (often rights-based litigation) to seek policy change. I also cast an eye to the future and discuss two key cases pending before the Supreme Court of Canada that are likely to have considerable impact on our system of publicly funded health care.

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[5] *Infra* note 73.
[6] *Infra* note 74.

Chapter Two: The Right to Health Care?

Why "Rights" Claims?

Access to health care services within a publicly funded system is of undeniable importance to Canadians.[7] In its recent report, the Romanow Commission stressed the value Canadians place on Medicare and described access to public health care as a "right of citizenship."[8] As governments grapple with the challenge of sustaining the Medicare system financially while meeting growing demands for services, individuals and groups seem increasingly willing to turn to the language of rights and *Charter* litigation to challenge government decisions to exclude certain services from the roster of publicly funded health care. Indeed, Dr. Nuala Kenny recently noted that "in the Canada of the twenty-first century, our medical benefits for individuals are being coupled with a strong sense of individual rights and freedoms."[9]

Assertions to rights to health care seem to stem from the value individuals place on access to health care. Because individuals believe access to health care services will save them from pain, illness, and even death, they value it and want to claim rights to it. Arthur Shafer has noted "good health is not simply one among many components of the

---

[7] A March 2003 public opinion poll found that a majority of respondents (78%) cited Medicare as the most prominent symbol of Canadian identity. Medicare even outranked hockey, a surprising fact considering the poll was conducted during the run-up to Stanley Cup playoff season. See Dennis Buecker "Medicare tops the flag, anthem and hockey as national icon; Queen last" *Canadian Press* (3 April 2003).

[8] *Supra* note 3 at xvi.

[9] Nuala Kenny, *What Good is Health Care?* (Ottawa: Canadian Healthcare Association Press, 2002) at 170. See also Barbara von Tigerstrom , "Human Rights and Health Care Reform: A Canadian Perspective" in Timothy A. Caulfield & Barbara von Tigerstrom, eds., *Health Care Reform & the Law in Canada: Meeting the Challenge* (Edmonton: University of Alberta Press, 2002) 157 where she states (at 157): "Rights language is often used to make claims about health care, ranging from general claims that the public has a right to health or to health care, to specific claims to particular treatments or standards of treatment."

'good life.' Health enjoys a high priority, perhaps the very highest priority in our hierarchy of values, because it is important for virtually every other life project we may have."[10] Mary Ann Baily also states:

> Most people agree that health care is a good of unusual importance. For individuals, health care plays a vital role in preventing pain and suffering, preserving the ability to live a normal life, providing information, and relieving worry. Finally, health care's importance in individual lives makes access to health care of deep symbolic significance, reflecting the concern members of society feel for one another.[11]

Canadian courts have recognized the value attached to health care in our society. Quite succinctly, the British Columbia Supreme Court has stated, "Health care has fundamental value in our society."[12] The Supreme Court of Canada has also alluded to the fundamental importance of health care: "Simply put, government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."[13] The B.C. Supreme Court has recently gone a step further, stating "Canadians are entitled to expect medical treatment for their physical and mental diseases. This is so, even where a disease cannot be 'cured.'"[14]

But is the simple fact that we value something sufficient to give rise to a claim to a legal right to that valuable thing? As Ronald Dworkin notes, some people may value vanilla ice cream but that does not mean they have a right to it.[15] Generally, things properly

---

[10] Arthur Shafer, *Waiting for Romanow: Canada's Health Care Values Under Fire* (Ottawa: Canadian Centre for Policy Alternatives, 2002) at 10.
[11] Mary Ann Baily, "Defining the Decent Minimum" in *Health Care Reform: A Human Rights Approach*, Audrey R. Chapman, ed. (Washington, D.C.: Georgetown University Press, 1994) 167 at 167.
[12] *R. v. Lewis* (1996), 139 D.L.R. (4th) 480 at 522 (B.C.S.C.).
[13] *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 at 544.
[14] *Auton*, B.C.S.C., *infra* note 74 at para. 109 [emphasis added].
[15] Ronald Dworkin, *Taking Rights Seriously* (Cambridge, Mass.: Harvard University Press, 1977) at 268. I do not suggest access to health care and access to ice cream are of equal importance, but Dworkin's comment provides (no pun intended) food for thought.

classified as rights are things we value - such as life and free expression - but the converse is not necessarily true. Nevertheless, litigants and academic commentators use the language of rights to argue in favour of *Charter* claims to publicly funded health care. Before turning to an analysis of such claims in Chapters Three and Four, I will briefly review several arguments against and for the proposition that individuals have a right to health care, in particular, a right to state-funded health care services. My purpose here is not to evaluate the merit of these arguments; rather, I canvas them because their competing positions are reflected in case law I discuss later. Besides, as Dieter Giesen observes, "[t]he existence of a right to health care has been one of the most problematic and debated issues in medical ethics and medical law,"[16] so I do not attempt to resolve this contentious and often ideologically-driven debate.

A Right to Health Care: The Positive and Negative Rights Debate

The issue of whether *Charter* rights, particularly ss. 7 and 15, encompass a right to health care brings into play broader questions about the basis for asserting a right to health care and what the content of such a right might be. Tom Beauchamp and James Childress note "[t]he debate about the right to health care has been characterized more by political rhetoric than careful analysis."[17] Indeed, it is tempting to formulate one's opinion about the existence of a right to health care based on one's normative view about how health care ought to be delivered in a society. For example, if one holds the view that health

---

[16] Dieter Giesen, "A right to health care? A comparative perspective" in Andrew Grubb & Maxwell J. Mehlman, eds., *Justice and Health Care: Comparative Perspectives* (Toronto: John Wiley & Sons, 1995) 287 at 287.

[17] Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001) at 241.

care is most efficiently and fairly delivered through a single-tier, publicly funded system, one may be more inclined to attempt to justify an argument in favour of a legally enforceable right to health care. Similarly, those who contend increased privatization in health care would enhance access to and quality of care may try to undermine the proposition that a right to public health care exists. However, in my view, it is necessary to separate the question of how health care ought to be delivered from the question of whether individuals have a right to health care.[18]

At the outset of this discussion, it is also useful to keep in mind the point Norman Daniels makes about the notion of a right to health care:

> Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation. Rather, we are justified in claiming a right to health care only if it can be harvested from an acceptable, general theory of distributive justice, or, more particularly, from a theory of justice for health care. Such a theory would tell us which kinds of right claims are legitimately viewed as rights. It would also help up specify the scope and limits of justified right claims.[19]

As mentioned above, the fact that access to health care (perhaps more accurately, the condition of being healthy[20]) is of such fundamental value for most individuals may lead to claims to a right to government funded health care without considering the basis for that right. Even though access to health care may be viewed as morally valuable, and

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[18] In "William Schabas v. Cordelia" (2000) 11 N.J.C.L. 247 (at 257), John Richards argues against "the nebulous notion of social rights" and contends that the fact government funds social programs, such as health care, has nothing to do with a legal right to such programs, but rather "is proof that, as societies become richer, the majority display a fundamental decency in domestic politics: they are prepared to tax themselves to pay for better schools, universal health programs, etc."

[19] Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985) at 5.

[20] See Chapter Three and *infra* notes 97 and 98 where I point out that access to health care services has less influence on health status than factors such as adequate income.

something a state should provide to its citizens assuming it has resources to do so, some writers argue against the concept of a right to health care.

The debate about a justification for a legal right to health care tends to turn on the distinction between negative and positive rights.[21] A right to health care involves a positive claim by individuals against the state requiring the latter to use its resources to provide for the delivery of health care services. (This general definition leaves aside the question about the scope of such a right.) The argument against a right to health care generally proceeds from the position that the state cannot be compelled to expend resources to provide services simply because individuals may need or want the services. John Richards argues that "constructing and running generous social programs requires political agreement among citizens to pay large taxes, and requires politicians to deliver administratively complex services. Courts cannot oblige people to pay taxes, and cannot administer complex organizations."[22]

Some commentators suggest it is inappropriate to use the language of rights in the context of health care or other social benefits. Karen Selick contends:

> There can be no more powerful claim than one that is justifiably called a right. We reserve the term 'right' to describe our highest, strongest, most compelling and inviolable claims. …recently there has been a trend towards defining rights to include much more than non-interference.

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[21] For a fuller discussion of philosophical perspectives on a right to health care and the contest between negative and positive rights claims, see e.g. Tamara Friesen, "The Right to Health Care" (2001) 9 Health L.J. 205, Thomas J. Bole and William B. Bondeson, eds. *Rights to Health Care* (Dordrecht: Kluwer Academic Publishers, 1991) and Richard A. Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* (Reading, Mass.: Addison-Wesley, 1997), esp. ch. 1, "A Positive Case for Positive Rights" and ch. 2, "Practical Obstacles to Positive Rights".

[22] *Supra* note 18 at 249.

> Many people have started to speak of rights to specific forms of wealth, such as food, shelter, health care, housing, education, and so on.[23]

Selick rejects the assertion that access to a benefit such as health care can be founded on a legal claim and argues one of the key problems with claiming a positive right is that it can only be fulfilled if the state has resources to do so. In contrast, a negative right arguably only requires that the person claiming the right be left alone and free from interference by others. Therefore, individuals can enjoy negative rights without infringing on the rights of others, but positive rights involve taking from some to give to others. As Selick puts it, "...the negative rights of all individuals can co-exist without conflict, but the positive rights of any single individual will necessarily bring him into conflict with at least one other human being."[24]

Additionally, some writers assert that classical, negative rights are truly fundamental and have clearly defined meanings that set them apart from positive rights. Richards argues this point forcefully when he states:

> Clear affirmation of the truly fundamental civil rights – freedom of assembly, of speech, or religious expression, and habeas corpus – and of democratic rights – above all, the right to vote – is a fundamental feature of civilized life. Compared with economic and social rights, these fundamental rights are straightforward and enforceable. ...
>
> On the other hand, there is no analogous agreement on the meaning of appropriate economic, social and cultural rights – either within or between countries. What is entailed in extending a rights-based discourse to this second category is the gutting of political life. It entails transforming political debates into a meaningless legal wish list...[25]

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[23] Karen Selick, "Rights and Wrongs in the Canadian Charter" in Anthony A. Peacock, ed., *Rethinking the Constitution: Perspectives on Canadian Constitutional Reform, Interpretation, and Theory* (Don Mills, Ont.: Oxford University Press Canada, 1996) 103 at 104.
[24] *Ibid.* at 105.
[25] *Supra* note 18 at 254.

Other commentators contend the distinction between negative and positive rights is artificial, particularly in regard to the claim that positive rights require the state to take action and to expend money but negative rights do not. Martha Jackman argues:

> Many classical rights, such as the right to vote, the right to a fair trial, freedom of expression and of association, do not come into existence automatically upon their recognition, but rather are dependent on concerted state regulation and action, rather than on the absence of state compulsion or control. It is therefore simplistic to suggest recognition and respect for classical rights imposes no corresponding obligation to act, or negligible costs only, on the state.[26]

Jackman also suggests the legal protections under ss. 7 and 15 of the *Charter* encompass a right to health care and contends the state has an obligation to provide publicly funded health care services. With regard to s. 7, Jackman states:

> ...a credible claim can be made that section 7 of the Charter guarantees a constitutional right to health care. In practical terms, a right to life and to security of the person is meaningless without access to health care, both in a preventive sense, and in the event of acute illness.[27]

On this view, the *Charter* provides individuals a positive right to health care services and the state has a corresponding duty to ensure the conditions necessary for the fulfillment of that right.

Arguments in favour of a right to health care accept the validity of positive rights claims against the state and tend to be based on one or both of the following general principles: (1) health care is a form of social protection because ill health is no different from other

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[26] Martha Jackman, "What's Wrong With Social and Economic Rights?" (2000) 11 N.J.C.L. 235 at 242.
[27] Martha Jackman, "The Regulation of Private Health Care Under the *Canada Health Act* and the *Canadian Charter*" [1995] 6:2 Const. Forum Const. 54 at 56.

threats against which the state offers protection to its citizens, such as crime; and (2) ill health bars individuals from competing equally for opportunities.[28]

Gary Jones articulates the first argument when he maintains "it is inconsistent to provide certain forms of protection that states commonly provide, without also furnishing a certain amount of health care."[29] This argument is based on the reality that almost all individuals at one time or another face illness or disability and need (at least basic) health care services. Just as the state protects citizens from threats such as aggression by criminals or military foes, the state ought to protect citizens from the threat of disease, the debilitating effects of which most people face more regularly than that of war or crime.

Furthermore, if the state does not use its collective resources to address this fundamental human need for health care, inequality among individuals will be exacerbated. This brings into play the second argument noted above, namely that those who suffer from ill health will be deprived of the opportunities available to those who have good health. Daniels bases his account of justice in the distribution of health care on the principle that individuals ought to have the chance to compete equally. He states that "impairment of normal functioning through disability and disease restricts an individual's opportunity relative to the portion of the normal range his skills and talents would have made available to him were he healthy."[30] Because ill health impairs normal functioning, the state ought to provide health care services. In the result, "by keeping people close to

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[28] Beauchamp & Childress, *supra* note 17 at 242.
[29] Gary E. Jones, "The Right to Health Care and the State" (1983) 33:132 Philosophical Q. 279 at 279.
[30] *Supra* note 19 at 33-34.

normal functioning, health care preserves the capabilities individuals need to participate in the political, social, and economic life of their society."[31]

Finally, some arguments favouring a right to health care are based simply on the view that health, itself, is "a basic good, an essential prerequisite to the exercise of personal autonomy and an irreducible condition of human flourishing."[32] Consequently, a state that governs in the best interests of its citizens ought to provide health care services. At this point, it should be noted these arguments do not propose that a right to health care will ensure equal health among individuals. The vagaries of disease and accidents will never strike all in the same measure and even with medical intervention provided at the state's behest, individuals will enjoy varying degrees of health.

Even if one accepts there is a sound basis upon which to defend a right to health care, the more troublesome inquiry is to determine the scope of such a right. Beauchamp and Childress describe two common views: (1) a right to health care means a right to access a decent minimum of care; and (2) a right to health care means a right of equal access to services, which, depending on the degree of wealth of a health care system, may be a minimal or more comprehensive level of service.[33] As I discuss in subsequent chapters, any judicial recognition of a right to health care under s. 7 of the *Charter* would most likely be limited to the first view (access to a decent minimum) while s. 15 litigation has focused on the second argument (equality of access to health care).

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[31] Normal Daniels & James E. Sabin, *Setting Limits Fairly: Can We Learn to Share Medical Resources?* (Oxford: Oxford University Press, 2002) at 15.
[32] *Supra* note 16 at 290.
[33] *Supra* note 17 at 244–247.

A decent minimum would provide basic health care for all individuals as well as coverage for catastrophic illness or injury. Outside the realm of this minimum level of care, individuals would be free to purchase health care insurance to cover other risks. It is argued that, as a matter of equality, a basic level of universal care is the least a state can provide for its citizens. Referring to the notorious fact that millions of American citizens have no health care coverage,[34] Ronald Dworkin states "...it is disgraceful that so prosperous a nation cannot guarantee even a decent minimum of medical care to all those over whom it exercises dominion."[35]

The idea of a right to equal access to health care ranges from a very narrow to a very broad meaning.[36] On the narrow view, a right of equal access provides that no one should be prevented from obtaining health care, but does not require state involvement in delivering the care. A moderate view is linked with the idea of a right to a decent minimum; that is, everyone is equally entitled to access that decent level of care. Finally, the broadest version of this view would require that every person have access to a comprehensive range of health care services.

Conclusion

In summary, arguments for or against a right to health care tend to turn on arguments about whether rights ought to be understood as "negative" or "positive": is the state's proper place to leave its citizens alone to enjoy the rights they have or is the state actively

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[34] Beauchamp & Childress note that over 40 million Americans have no health insurance. *Ibid.* at 240.
[35] Ronald Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge, Mass.: Harvard University Press, 2000) at 318.
[36] Beauchamp & Childress, *supra* note 17 at 244.

to provide goods and services so citizens may enjoy rights? Timothy Christian sums up the distinction as follows and provides an example that leads to the question of whether the *Charter* encompasses a right to public health care:

> A negative right is thus the absence of coercion which impairs enjoyment of the right. It is to be contrasted with a positive right which would require the actual provision of the matter to which there is a right. An example will make the distinction clear. The Charter guarantees the right to life. Does this mean that the Charter is a barrier protecting everyone against state deprivation of their life, or does it mean that there is a positive obligation on the state to provide the goods and services necessary for the sustenance of life? Is it a statement of civil liberties or a manifesto of social welfare benefits?[37]

Although this distinction between negative and positive rights has been criticized and rejected by some, its influence on judicial reasoning is undeniable, particularly in relation to s. 7 claims for social benefits, including publicly funded health care services. The next chapter analyses this issue in detail.

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[37] Timothy J. Christian, "Section 7 of the Charter of Rights and Freedoms: Constraints on State Action" (1984) 22 Alta. L.R. 222 at 227.

Chapter Three: A Section 7 Right to Public Health Care?

Introduction

This chapter focuses on the use of s. 7 of the *Charter* to claim that government has an obligation to fund specific health care services. Such a claim is based on the argument that, without access to particular services, an individual will be deprived of life, liberty and/or security of the person. As I discuss in detail below, there are a number of problematic aspects in regard to a s. 7 claim to a positive right to publicly funded health care services, both from a strictly legal perspective and from a broader health policy perspective. These problems include: (1) the weight of jurisprudential authority does not support an interpretation of s. 7 that imposes a positive obligation on government to secure the life, liberty or personal security of individuals by providing health care services; (2) an interpretation of s. 7 that imposes obligations on governments to provide particular social benefits, such as health care services, will expand the scope of judicial review into complex policy arenas which, arguably, are not justiciable; and (3) for those who advocate *Charter* litigation to secure social and economic rights, such as health care and income security, it is unlikely s. 7 challenges will be an effective means to bring about health policy reform and expand the scope of our health care system. Overall, my thesis in this chapter is that s. 7 claims to a positive right to health care have little chance of success and I suggest that to expect significant health care reform through s. 7 litigation is to place too high an expectation on the *Charter*.

I begin by reviewing case law that has addressed s. 7 in the health care context. These cases reveal an evolution in the types of claims advanced under s. 7; the first cases I discuss assert classical, negative conceptions of rights – claims about freedom to make decisions about personal health care treatment free from undue state interference - while the second group of cases focuses on positive claims in which litigants ask courts to order governments to provide certain health care services. I then consider whether courts are likely to accept the claim that s. 7 encompasses a right to publicly funded health care and conclude this is unlikely, particularly in light of the Supreme Court of Canada's recent decision in *Gosselin v. Québec*.[38] Even if courts were to expand the interpretation of s. 7 in this manner, the challenge would then lie in defining the scope of a *Charter* right to health care, which is the final subject I discuss.[39]

Freedom from Government Restriction in Health Care Decision-Making

Relevant provisions of the *Charter* state:

> (1) The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
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> (7) Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

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[38] (2002) 221 D.L.R. (4th) 257 (S.C.C.), aff'g [1999] R.J.Q. 1033 (C.A.), [1992] R.J.Q. 1647 (S.C.) [*Gosselin*].

[39] For additional recent commentary on the application of s. 7 in the health care context, see e.g. Commission on the Future of Health Care in Canada, *The Implications of Section 7 of the Charter for Health Care Spending in Canada: Discussion Paper No. 31* by Martha Jackman (Saskatoon: Commission on the Future of Health Care in Canada, 2002), Commission on the Future of Health Care in Canada, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs? Discussion Paper No. 20* by Donna Greschner (Saskatoon: Commission on the Future of Health Care in Canada, 2002), and Benjamin Berger, "Using the *Charter* to Cure Health Care: Panacea or Placebo?" (2003) 8 Rev. Const. Studies 20.

Rights under s. 7 are not absolute. First, these rights are limited by the fact that a person may be deprived of them, as long as any deprivation accords with principles of fundamental justice. Second, a s. 7 violation may be justified under s. 1 of the *Charter*.[40]

The first category of *Charter* cases I review involves claims about freedom to make decisions about one's health and medical treatment without unwarranted state-imposed restrictions. These cases all involve s.7 challenges to state action – specifically, criminalization of certain conduct.

R. v. Morgentaler[41] involved a s. 7 challenge to the *Criminal Code* provisions that criminalized abortion unless certain requirements were met. Specifically, the impugned provision required a woman seeking an abortion to appear before a three-member therapeutic abortion committee, obtain a certificate authorizing the abortion and, finally, find a physician other than one on the committee to perform the abortion. Because of this process, many women faced significant delays in obtaining abortion services, particularly in areas outside large urban centres.

[40] However, various commentators have noted it is difficult to justify a breach of s. 7 because a deprivation of rights that does not accord with principles of fundamental justice is unlikely to be demonstrably justifiable in a free and democratic society. See e.g. Peter W. Hogg, *infra* note 104 at 916.
[41] [1988] 1 S.C.R. 30 [*Morgentaler*].

The majority of the Supreme Court of Canada[42] held the *Criminal Code* provision violated s. 7 of the *Charter* and could not be justified under s. 1. The judges who found a breach of s. 7 held that "security of the person" under s. 7 protected a woman's physical and mental integrity from serious state interference in the criminal law context. For example, Beetz J. stated "security of the person must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction."[43] However, he cautioned he was not limiting the application of s. 7 in other circumstances.[44]

Similarly, Dickson C.J. confined his views on s. 7 to the criminal law context, but did not foreclose a broader application:

> ...state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of the security of the person. It is not necessary in this case to determine whether the right extends further, to protect either interests central to personal autonomy, such as a right to privacy, or interests unrelated to criminal justice.[45]

Rodriguez v. British Columbia[46] also involved a s. 7 challenge in the health care context. Sue Rodriguez challenged the constitutionality of the *Criminal Code* prohibition against assisted suicide. Ms. Rodriguez had amyotrophic lateral sclerosis (commonly known as Lou Gehrig's disease), a fatal disease that progressively impairs basic physical capacities, such as breathing, swallowing, moving and speaking, but leaves the mind intact. Ms. Rodriguez understood the inevitable path of her disease and wanted to have the ability to

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[42] Dickson C.J., Lamer, Beetz, Estey and Wilson JJ. all found an unjustifiable s. 7 violation. McIntyre and La Forest JJ. dissented and found no breach of s. 7.
[43] *Supra* note 41 at 81.
[44] *Ibid.* at 89.
[45] *Ibid.* at 56.
[46] [1993] 3 S.C.R. 519 [*Rodriguez*].

end her life when her suffering became intolerable. However, when that time came, she would physically be unable to commit suicide without assistance and wanted a physician to help her to die, but any physician who aided her risked criminal sanction.

Ms. Rodriguez sought an order, based on ss. 7, 12 and 15 of the *Charter*, declaring unconstitutional the *Criminal Code* prohibition against assisted suicide.[47] In respect of s. 7, Ms. Rodriguez argued the impugned law deprived her of the right to live the last of her life in dignity and the right to be free from state interference in making fundamental decisions about her life or, more precisely, about her death.

In a narrow majority, the Supreme Court of Canada dismissed Ms. Rodriguez's claim.[48] Sopinka J., writing for the five justices who comprised the majority of the Court, held that though the *Criminal Code* prohibition abridged Ms. Rodriguez's right to security of the person under s. 7, that infringement accorded with principles of fundamental justice. With regard to the nature of the interest captured by the right to security of the person under s. 7, Sopinka J. stated:

> There is no question then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.[49]

Although Sopinka J. found Ms. Rodriguez's interests under s. 7 were engaged, he held she was not deprived of her rights contrary to the principles of fundamental justice. He

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[47] Section 12 of the *Charter* is the prohibition against cruel and unusual punishment.
[48] Sopinka, La Forest, Gonthier, Iacobucci and Major JJ. constituted the majority. Lamer C.J., L'Heureux-Dubé, Cory, and McLachin JJ. dissented.
[49] *Supra* note 46 at 588. As in the *Morgentaler* decision, Sopinka J.'s reference to criminal prohibitions limits the scope of the s. 7 right.

held that the state's interest in protecting vulnerable individuals and safeguarding human life justified the prohibition on assisted suicide.[50]

In her dissent, McLachlin J. (as she then was) held the impugned law violated Ms. Rodriguez's right to security of the person in a manner inconsistent with principles of fundamental justice. McLachlin J. stated that security of the person "has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body."[51] She further stated that the prohibition against assisted suicide was marked by an arbitrariness and lack of respect for individual choice that did not accord with principles of fundamental justice. Ultimately, in her view, this violation could not be justified under s. 1 of the *Charter*.

In *Rodriguez*, the respondent apparently took the position that "the appellant's problems [were] due to her physical disabilities caused by her terminal illness, and not by governmental action."[52] Sopinka J. explicitly rejected this argument. However, this argument reappears in other cases and, as discussed below, in at least one, a court found the assertion persuasive.

The more recent Ontario case of *R. v. Parker*[53] involved a challenge to provisions of the federal *Controlled Drugs and Substances Act* (formerly the *Narcotic Control Act*) prohibiting possession of marijuana. Mr. Parker suffered from a severe form of epilepsy and grew marijuana for his own use to control his seizures. Upon being charged with

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[50] *Ibid.* at 595-608.
[51] *Ibid.* at 415-416.
[52] *Ibid.* at 387.
[53] (2000) 49 O.R. (3d) 481 (C.A.) [*Parker*].

possession of marijuana, an offence punishable by imprisonment, Mr. Parker argued the offence provisions violated his rights under s. 7 of the *Charter* because he faced criminal sanction for using marijuana to meet a medical need.

The trial court agreed with Mr. Parker and granted a stay of the possession charge.[54] On appeal, the Ontario Court of Appeal agreed Mr. Parker's rights to liberty and security of the person were violated by the untenable choice between safeguarding his health and risking imprisonment. With respect to the content of the right to liberty in s. 7, the Court of Appeal stated that the threat of prosecution and imprisonment under the impugned legislation engaged Mr. Parker's liberty interests. In the circumstances of this case, the Court held the risk of deprivation of liberty was not in accordance with principles of fundamental justice, nor could it be justified under s. 1 of the *Charter*. Regarding the right to security of the person, the Court reiterated language from *Morgentaler* to the effect that state interference with an individual's physical and psychological integrity violates security of the person. Further, the Court emphasized that "[d]eprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health also constitutes a deprivation of security of the person."[55]

In summary, the notion of any right to health care raised by these cases can largely be confined to freedom <u>from</u> state interference that criminalizes conduct regarding one's own body and health. The claimants had not asked the courts to order the government to

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[54] [1997] O.J. No. 4550 (QL) (Ont. Ct. Prov. Div.).
[55] *Supra* note 53 at para. 97.

provide access to particular health care services.[56] Although these s. 7 cases all involved the threat of criminal sanction, the Supreme Court of Canada has since interpreted s. 7 as having application outside the criminal justice system.

In *New Brunswick (Minister of Health and Community Services) v. G.(J.)*,[57] a case concerning "the issue of whether indigent parents have a constitutional right to be provided with state-funded counsel when a government seeks a judicial order suspending such parent's custody of their children,"[58] the Supreme Court held that the s. 7 right to security of the person extends beyond the criminal law context. The Court held that the state's action in seeking custody over a child "directly engages the justice system and its administration"[59] and, in the circumstances of the case before it, the Court ruled the government was obliged to fund counsel to represent the parent in the custody proceeding. Further, in *Blencoe v. British Columbia (Human Rights Commission)*,[60] the majority of the Court[61] affirmed s. 7 applies outside the criminal law sphere, in that case, in the context of adjudication of a human rights complaint. In a partially dissenting judgment, LeBel J.[62] would have decided the case on administrative law principles and found it unnecessary to offer a definitive view of the application of s. 7 to the facts of the case. He stated:

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[56] However, I note these cases implicitly require some state involvement to realize the rights the claimants asserted. For example, *Morgentaler* involved access to abortion services that are covered under public health insurance. Ms. Rodriguez's claim to assisted suicide generally would involve the participation of a state-paid physician. Finally, *Parker* would likely involve some government regulation of marijuana prescribed for medicinal use.
[57] [1993] 3 S.C.R. 46.
[58] *Ibid.* at para. 1.
[59] *Ibid.* at para. 66.
[60] [2000] 2 S.C.R. 307.
[61] McLachlin C.J., L'Heureux-Dubé, Gonthier, Major and Bastarache JJ.
[62] With whom Iacobucci, Binnie and Arbour JJ. agreed.

> We must remember though that s. 7 expresses some of the basic values of the *Charter*. It is certainly true that we must avoid collapsing the contents of the *Charter* and perhaps of Canadian law into a flexible and complex provision like s. 7. But its importance is such for the definition of substantive and procedural guarantees in Canadian law that it would be dangerous to freeze the development of this part of the law. The full impact of s. 7 will remain difficult to foresee and assess for a long while yet. Our court should be alive to the need to safeguard a degree of flexibility in the interpretation and evolution of s. 7 of the *Charter*. At the same time, the Court should remind litigants that not every case can be reduced to a *Charter* case.[63]

The expansion of s. 7 beyond a narrow, criminal law focus may be interpreted as an opening for claimants to use the *Charter* to challenge government funding decisions that restrict or deny access to particular medical treatments, arguing that lack of access to such treatments violates their rights to life, liberty or security of the person. Indeed, litigants have asked courts to recognize rights under s. 7 to specific health care services or treatments. However, despite the broadening of the scope of s. 7, as I discuss below, I am skeptical courts will use s. 7 to compel governments to fund particular health care services.

Access to Specific Treatments

Brown v. British Columbia[64] is one of the first attempts to use s. 7 to obtain funding for a particular medical treatment. In that case, two individual plaintiffs as well as the Vancouver Persons with AIDS Society challenged the B.C. government's decision to require persons with HIV/AIDS to pay for part of the cost of expensive drug therapy. At the time, azidothymidine (AZT) was the only medication available to slow the progression of the disease and was available to HIV/AIDS patients in British Columbia

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[63] *Supra* note 60 at para. 188.
[64] [1990] B.C.J. No. 151 (S.C.) (QL) at 14 [*Brown*].

enrolled in clinical trials. In 1987, the Ministry of Health put AZT on the provincial drug plan, which required patients, except those on social assistance or in long-term care facilities, to pay $2000 per year to receive the drug. All other provinces covered the full cost of AZT therapy for HIV/AIDS patients.[65]

The plaintiffs in *Brown* alleged the province's policy regarding AZT funding violated their rights under ss. 7 and 15 of the *Charter*. With regard to s. 7, the plaintiffs argued the policy "violate[d] their security because it affect[ed] their health, both physically and psychologically, imposing stress, stigma, perception of discrimination and loss of self-esteem." [66] The plaintiffs also argued the policy discriminated against them on the basis of physical disability and sexual orientation (since the majority of individuals known to be infected with HIV/AIDS were homosexual men).

The B.C. Supreme Court rejected these arguments. With regard to s. 7, Coultas J. concluded the right the plaintiffs asserted was economic in nature and thus not within the proper scope of s. 7.[67] He was also persuaded by the argument that any deprivation the plaintiffs suffered was due to their disease, not government policy. In his words:

> The plaintiffs suggest that the funding policy is a deprivation under s. 7. But this is not a case where the life, liberty, or security of the person is directly infringed by the law. The deprivation lies in the fact that they are infected with a debilitating and incurable disease.[68]

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[65] *Ibid.* at 5.
[66] *Ibid.* at 14.
[67] In *Irwin Toy Ltd. v. Québec (Attorney General)*, [1989] 1 S.C.R. 927 at 1003, the Supreme Court of Canada rejected the notion that s. 7 protects "economic rights as generally encompassed by the term 'property'."
[68] Supra note 64 at 15.

As noted above, the Supreme Court of Canada in *Rodriguez* specifically rejected this line of reasoning.

In another early case, *Ontario Nursing Home Association v. Ontario*,[69] the Ontario High Court of Justice rejected a s. 7 claim seeking additional government funding for nursing homes. The claimants alleged elderly residents of nursing homes would receive better quality of care if the government provided greater funding. The Court dismissed the s. 7 argument summarily, noting:

> It is true with greater funding [the individual claimant] might receive more care but it cannot be said that he is being deprived of his rights to life, liberty or security of the person. The section does not deal with property rights and as such does not deal with additional benefits which might enhance life, liberty or security of the person.[70]

In *Fernandes v. Director of Social Services*,[71] the Manitoba Court of Appeal considered a claim by a long-term care patient who sought additional funding from the government to allow him to hire a personal attendant so he could live at home rather than in hospital. The patient alleged the government's denial of his funding request violated his rights under ss. 7 and 15. In regard to s. 7, the Court referred to the then-prevailing interpretation that s. 7 is concerned primarily with criminal law proceedings and protects

> …individuals against the state when it invokes the judiciary to restrict a person's physical liberty through the use of punishment or detention, when it restricts security of the person, or when it restricts other liberties by employing the method of sanction and punishment traditionally within the judicial realm.
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> The desire to live in a particular setting does not constitute a right protected under s. 7 of the *Charter*.[72]

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[69] (1990), 74 O.R. (2d) 365 (H.C.J.).
[70] *Ibid.* at 378.
[71] (1993), 7 Admin. L.R. (2d) 153 (Man. C.A.).
[72] *Ibid.* at 166, citing Lamer J. in *Reference re ss. 193 & 195 of the Criminal Code*, [1990] 1 S.C.R. 1123.

These early s. 7 cases seeking to impose on government an obligation to fund particular services met with no success and this trend has continued in more recent cases such as *Cameron v. Nova Scotia*[73] and *Auton v. British Columbia*.[74] *Cameron* involved a claim by an infertile couple for government funding for fertility treatments, in-vitro fertilization ("IVF") and intra-cytoplasmic sperm injection ("ICSI").[75] Both procedures are costly and have limited success rates. The Nova Scotia health insurance plan did not fund either procedure and the couple sought treatment in Ontario and Alberta at their own expense. They alleged the procedures were medically necessary for infertile couples and argued the lack of public funding for the procedures violated their rights under ss. 7 and 15 of the *Charter*.

Both the Nova Scotia Supreme Court and Court of Appeal dismissed the couple's claim and, at both levels, the analysis focused on the claimants' s. 15 arguments (which I discuss in detail in Chapter Four). The trial court found no violation of the claimants' equality rights under s. 15 and dismissed the s. 7 claim, agreeing with the government's submission that "finding the public funding of particular medical services to be considered an element of the right to life, liberty or security of person would expand the parameters of judicial review, well beyond its present scope."[76]

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[73] (1999), 177 D.L.R. (4th) 611 (N.S.C.A.) [*Cameron*, N.S.C.A.), aff'g (1999), 172 N.S.R. (2d) 227 (S.C.) [*Cameron*, N.S.S.C.), leave to appeal to S.C.C. refused, [1999] S.C.C.A. No. 531 (QL).

[74] (2002), 6 B.C.L.R. (4th) 201 (C.A.) [*Auton*, B.C.C.A.], aff'g (2000), 78 B.C.L.R. (3d) 55 (S.C.) [*Auton*, B.C.S.C.], leave to appeal to S.C.C. granted, [2002] S.C.C.A. No. 510 (QL).

[75] During IVF, egg cells are introduced to sperm cells in a laboratory in the hopes fertilization will occur. If one or more eggs are fertilized, they are then surgically implanted into a woman's uterus, again in hopes a successful pregnancy will result. ICSI is a form of IVF in which a single sperm is injected into an egg cell, forcing fertilization to occur. See *Cameron*, N.S.C.A., *supra* note 73 at paras. 5 & 6.

[76] *Cameron*, N.S.S.C., *ibid.* at para. 160.

The British Columbia court decisions in *Auton* are the most recent examples of litigants using the Charter to seek public funding for specific medical treatment. This case involved a claim by children with autism and their parents seeking government funding for a particular form of treatment for autism referred to as early intensive behavioural intervention. Without appropriate therapy, children with autism may suffer many harms: self-injurious behaviour; inability to communicate effectively with those around them; social isolation and stigmatization; and a likelihood of institutionalization in adulthood.[77] Because of this poor prognosis, the claimants argued the British Columbia government's refusal to fund early intervention therapy deprived the children of their rights under ss. 7 and 15 of the *Charter*. The claimants asked the Court to order the government to fund the therapy, which involves a therapist working one-on-one with an autistic child for up to several years, at the cost of $45,000 - $60,000 annually.[78]

Both the British Columbia Supreme Court and the Court of Appeal found the government's refusal to fund early intervention for children with autism violated their s. 15 equality rights. The trial judge declined to deal with the petitioners' s. 7 argument and, although the appeal decision turned on s. 15, Saunders J.A. offered her comments on s. 7:

> When the *Charter* was first presented considerable debate ensued as to whether it could apply to provide a positive entitlement to health care. In my view, in the context of this case, it does not. The impugned measure does not impinge on the right to life. Jurisprudence to date suggests that the right to liberty concerns physical liberty or "an irreducible sphere of personal autonomy", circumstances which do not result from the funding and treatment decision at issue in this case. And while there may be room for debate as to whether the right to security of the person may be

[77] *Auton*, B.C.S.C., at paras. 10-13.
[78] *Ibid.* at para. 24.

> infringed in circumstances such as are here presented, I consider that the underinclusiveness of the health system, even as it relates to children, would not violate a principle of fundamental justice.[79]

Summary

Cases like *Morgentaler, Rodriguez,* and *Parker* invoked conceptions of rights to liberty and security of the person under s. 7 that are most readily understood as negative rights. That is, in each case, the claimants challenged government intrusion (in the form of criminal prohibitions) into their lives and argued individuals have a sphere of autonomy in which government should not interfere. In *Morgentaler*, this sphere related to women's reproductive choices; in *Rodriguez*, to decisions about controlling the timing and manner of one's death; and, in *Parker*, to decisions about medicinal use of marijuana to control a disease. In this sense, these cases may rest more easily with those who object to using the *Charter* to assert positive rights claims.[80]

Such cases may be distinguished from circumstances like *Cameron* and *Auton* where litigants rely on the *Charter* to make claims for specific health care services. These latter cases indicate an evolution in the use of the *Charter* to challenge government resource allocation decisions and shape health care funding to meet the interests of particular litigants.

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[79] *Auton,* B.C.C.A., *ibid.* at para. 37 [internal citations omitted].
[80] This is not to say that these cases did not have controversial aspects, since any *Charter* case that ends up before the Supreme Court of Canada is likely to evoke significant debate.

Will Courts Recognize a Section 7 Right to Public Health Care?

As *Cameron* and *Auton* show, courts have been reluctant to address s. 7 claims that challenge government decisions to deny public funding for specific health care services. The Supreme Court of Canada's recent decision in *Gosselin v. Québec* suggests this trend is likely to continue and it seems improbable a majority of the Court will expand the scope of s. 7 to include a right to government-funded health care services.

Gosselin involved a class action against the Province of Québec challenging the government's decision to reduce welfare benefits for certain categories of recipients. The claimants alleged this reduction violated their rights to life and security of the person under s. 7 because it brought their income to a level at which they could not obtain the necessaries for life.[81] The trial judge dismissed the action on the basis that the rights claimed were economic in nature and therefore not protected under s. 7. As the following passage indicates, the judge's reasoning turned on the contest between negative and positive liberties:

> There is a difference between, on one hand, economic and social rights that depend on active intervention and use of important State resources, and on the other, civil and political rights that depend only on recourse to political and judicial institutions regardless of a State's level of development.[82]

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[81] The claimants also alleged the welfare scheme violated s. 15 of the *Charter* and s. 45 of the Québec *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, which provides for a right to "measures of financial assistance and to social measures provided for by law, susceptible of ensuring such person an acceptable standard of living."

[82] Q.S.C. decision, *supra* note 38 at para. 213 [translated by author].

Ultimately the trial court concluded s. 7 does not encompass a right to social assistance as asserted by the claimants and the *Charter* does not authorize a court to substitute "its judgment in social and economic matters for the judgment of legislative bodies…"[83]

Similarly, the majority of the Supreme Court of Canada dismissed the s. 7 claim.[84] Chief Justice McLachlin ruled s. 7 does not encompass a "right to a level of social assistance sufficient to meet basic needs"[85] for two key reasons: (1) because "the dominant strand of jurisprudence on s. 7 sees its purpose as guarding against certain kinds of deprivations of life, liberty and security of the person, namely, those 'that occur as a result of an individual's interaction with the justice system and its administration'" [86] and (2) "[n]othing in the jurisprudence thus far suggests that s. 7 places a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person. Rather s. 7 has been interpreted as restricting the state's ability to deprive people of these."[87] She also stated the "frail platform provided by the facts of this case cannot support the weight of a positive state obligation of citizen support."[88] While the majority in *Gosselin* rejected the s. 7 claim, McLachlin C.J. noted the issue of whether s. 7 can apply outside the administration of justice remains an unanswered question and stated "[o]ne day s. 7 may be interpreted to include positive obligations. …I leave open the possibility that a

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[83] *Ibid.* at para. 217 [translated by author].
[84] McLachlin C.J., Gonthier, Iacobucci, Major, Bastarache, Binnie and LeBel JJ. found no s. 7 breach. L'Heureux-Dubé and Arbour JJ. found a s. 7 violation that was not justifiable under s. 1.
[85] *Supra* note 38 at para. 76.
[86] *Ibid.* at para. 77 [internal citation omitted].
[87] *Ibid.* at para. 81.
[88] *Ibid.* at para. 83.

positive obligation to sustain life, liberty, or security of the person may be made out in special circumstances."[89]

In her dissent, Arbour J. (with whom L'Heureux-Dubé J. concurred) held s. 7 includes a "positive dimension," and "[f]ew would dispute that an advanced modern welfare state like Canada has a positive moral obligation to protect the life, liberty and security of its citizens."[90] She conceded that "[t]here is considerably less agreement, however, as to whether this positive moral obligation translates into a legal one."[91] Nonetheless, Arbour J. held s. 7 encompasses a right to assistance from the state to meet "basic needs of subsistence."[92] Arbour J. held that a right to "basic means of subsistence" is vastly different from a corporate-commercial economic right and asserted that restricting s. 7 to "one's dealings with the justice system and its administration"[93] is contrary to a generous and purposive interpretation of the *Charter* and is "inconsistent with the vision of the Constitution as a 'living tree.'"[94]

In view of its decision in *Gosselin*, how might the Supreme Court respond to a s. 7 claim for access to state-funded health care services? It seems probable the claim would fail because it does not involve interaction with the justice system and it rests on the (so far) rejected argument that the state must ensure a person's enjoyment of personal security. However, would a need for certain health care services constitute the "special

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[89] *Ibid.* at paras. 82 & 83.
[90] *Ibid.* at para. 308.
[91] *Ibid.*
[92] *Ibid.* at para. 311.
[93] *Ibid.* at para. 317.
[94] *Ibid.*

circumstances" that, according to McLachlin C.J., would warrant an expanded interpretation of s. 7? On the more generous interpretation of s. 7 offered by Arbour J., would governments be obliged to fund particular therapies? Turning back to the *Cameron* and *Auton* examples, it seems likely the facts and interests at play in *Cameron* (a professional couple seeking fertility treatment to fulfill a desire to have a biologically related child) may not be sufficiently compelling to warrant imposing a constitutional obligation on government to fund the treatment. However, the facts in *Auton* are certainly more sympathetic. The trial judge alluded to this when she stated "autism is a disability so severe and comprehensive that it affects all aspects of [the children's] lives. Their core medical need is for treatment that will permit them to break out of their isolation."[95] Yet, despite the fact the case involved a vulnerable group (children), a devastating disability (autism), and evidence of a promising therapy (early behavioural intervention), the British Columbia courts were unwilling to recognize the s. 7 claim. So, if these seemingly compelling circumstances are not sufficient to trigger s. 7, it is difficult to think of facts that would warrant an extension of s. 7 doctrine to compel government to fund specific health care services.

Though the Supreme Court of Canada has granted leave to appeal in *Auton*, the Court may well confine its ruling to s. 15 and avoid addressing the s. 7 claim. This seems likely, considering the trial judge did not address s. 7 at all and the Court of Appeal dealt with s. 7 in four short paragraphs. Also, as a matter of practice, if a court can dispose of a case under one *Charter* section, it may decline to rule on other *Charter* arguments litigants may have raised. Further, given its recent ruling in *Gosselin*, the Court may not

[95] *Auton*, B.C.S.C., *supra* note 74 at para. 134.

be inclined to revisit so soon the question of whether s. 7 encompasses a positive right to a state-funded benefit. Absent a landmark ruling from the Court in *Auton* regarding the scope of s. 7, the weight of existing *Charter* jurisprudence does not support a positive claim to state-funded health care: as Bernard Dickens observes, "[w]hile the Charter offers some protection against government interference with an individual's pursuit of their own health, it does not give government an affirmative mandate to furnish people with the resources needed to improve their health..."[96]

The Right to Health Care and Other Social Rights Claims

While I am skeptical the Supreme Court of Canada will interpret s. 7 as encompassing a positive right to public health care, a few words should be said about the incongruence that would result if the Court recognized a *Charter* claim to health care after rejecting the claim in *Gosselin* to a right to income assistance. If the basis of a s. 7 claim to health care services is to assure a reasonable standard of health for all persons, then any arguments regarding a s. 7 right to health care should apply *a fortiori* to a right to a minimum level of economic security. Public health practitioners have long pointed to evidence that poverty is a more fundamental cause of ill health than lack of access to health care.[97] Angus Deaton states the correlation clearly:

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[96] Bernard Dickens, "The Law's Contribution to Sound Health Policy" in Margaret Somerville, ed., *Do We Care? Renewing Canada's Commitment to Health. Proceedings of the First Directions for Canadian Health Care Conference* (Montréal: McGill-Queen's University Press, 1999) 137 at 138.

[97] See e.g. Michael Marmot, "The Influence of Income on Health: Views of an Epidemiologist" (2002) 21:2 Health Affairs 31; John W. Lynch, George A. Kaplan & Sarah J. Shema, "Cumulative Impact of Sustained Economic Hardship on Physical, Cognitive, Psychological, and Social Functioning" (1997) 337 New Engl. J. Med. 1889; and Marcia Angell, "Privilege and Health – What is the Connection?" Editorial (1993) 329 New Eng. J. Med. 126; and Robert G. Evans, Morris L. Barer and Theodore R. Marmor, eds. *Why Are Some People Healthy and Others Not? The Determinants of Population Health* (New York: Aldine de Gruyter, 1994).

> Poorer people die younger and are sicker than richer people; indeed, mortality and morbidity rates are inversely related to many correlates of socioeconomic status such as income, wealth, education, or social class. …economic deprivation is strongly related to ill health…[98]

If courts use the *Charter* to compel government to provide publicly funded access to specific health care services, then, as a matter of consistency, those same *Charter* rights ought to apply to other social rights, such as a minimum level of income assistance from the state.

Some academic commentators in Canada argue s. 7 of the *Charter* may be used to assert social or economic rights such as a right to a minimum level of income. Martha Jackman argues:

> In principle, the *Canadian Charter of Rights and Freedoms*, and in particular the right to life, liberty and security of the person under s. 7, and the right to equal protection and equal benefit of the law under s. 15, provide a solid basis for challenges to inadequacies and inequities in social welfare legislation.[99]

With regard to s. 7, it is argued that rights to liberty and security of the person are violated for people who live in poverty without adequate income to meet their basic needs.[100] To a large degree, this argument is similar to the proposition that the state ought to provide health care for its citizens. Just as it is inevitable people will become sick and need health care, it is also predictable some people will have inadequate resources to provide for basic needs such as food and shelter. Therefore, it is arguable

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[98] Angus Deaton, "Policy Implications of the Gradient of Health and Wealth" (2002) 21:2 Health Affairs 13 at 13.
[99] Martha Jackman, "Poor Rights: Using the *Charter* to Support Social Welfare Claims" (1993) 19 Queen's L.J. 65 at 66.
[100] For this argument based on "security of the person", see e.g. John D. Whyte, "Fundamental Justice: The Scope and Application of S. 7 of the Charter" (1983) 13 Man. L.J. 453.

the reasoning used to justify a positive obligation on the state to provide health care could also demand at least a minimum of social welfare assistance.

Henry Shue expresses the argument in favour of such rights as follows:

> The most fundamental rights are social guarantees for individuals against threats to which they are otherwise most vulnerable: "Basic rights are a shield for the defenseless against at least some of the more devastating and more common of life's threats." The vulnerability of human beings is the result of our physical fragility.
> ...
> Sometimes it is helpful to divide human vulnerability into physical security and economic security: I call the latter subsistence.
> ...
> Subsistence rights...constitute social guarantees against one of the most devastating forms of helplessness to which humanity is vulnerable: a form of helplessness that can prevent the enjoyment of any other rights, not to mention the achievement of goals far more elevated than mere survival. A guarantee of subsistence for those who *cannot* provide it for themselves is a necessary condition for a genuine and meaningful guarantee of anything else, including the substances of other rights.[101]

This proposition mirrors the argument that individuals have a right to health care because disease and disability impair our capacity to participate meaningfully in society and enjoy our freedoms.

However, as *Gosselin* demonstrates, courts have been reluctant to recognize such rights. As another example, the Ontario Court of Justice ruled in *Masse v. Ontario*[102] that the provincial government's decision to reduce welfare benefits did not violate the claimants' rights under ss. 7 and 15 of the *Charter*. The Court held s. 7 of the *Charter* did not include a right to social assistance benefits. Again, the Court's decision turns on the

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[101] Henry Shue, "Subsistence Rights: Shall We Secure *These* Rights?" in Robert A. Goldwin & William A. Schambra, eds., *How Does the Constitution Secure Rights?* (Washington, DC: American Enterprise Institute for Public Policy Research, 1985) 74 at 83, 84 & 86 [emphasis in original; internal citation omitted].

[102] (1996), 134 D.L.R. (4th) 20 (Ont. Ct., Gen. Div.).

question of whether the *Charter* confers positive rights to state assistance. O'Driscoll J. stated in no uncertain terms that it does not:

> ...s. 7 does not provide the [a]pplicants with any legal right to minimal social assistance. ...s. 7 does not confer any affirmative right to governmental aid. ... Moreover, in the absence of extreme language, the Charter does not impose positive obligations on the government but rather constrains government action.[103]

Stating that the Court had no authority to intrude on government's authority to set policy regarding social benefit schemes, both O'Driscoll and O'Brien JJ. cited the following passage from Peter Hogg's text on constitutional law: "As Oliver Wendell Holmes would have pointed out, these are the issues upon which elections are won and lost; the judge needs a clear mandate to enter that arena, and s. 7 does not provide that clear mandate."[104]

Some academic lawyers, including Jackman, have criticized decisions like *Gosselin* and *Masse*:

> By characterizing these claims in purely economic terms and therefore excluding them from the ambit of s. 7, these courts are ignoring fundamental values of human welfare, personal security, individual autonomy, and human dignity, without with the constitutional right to life, liberty, and security of the person is essentially meaningless.[105]

Jackman also notes:

> Underlying these decisions [where courts have dismissed various social rights claims] is a rejection of the idea that the *Charter* creates positive rights which courts can rely on to compel governments to increase levels

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[103] *Ibid.* at paras. 350, 351 & 357.
[104] *Ibid.* at paras. 226 & 364. See Peter W. Hogg, *Constitutional Law of Canada,* Stud. Ed. (Scarborough: Carswell, 2002) at 967.
[105] *Supra* note 99 at 79.

> of social welfare spending whether by expanding the scope of programs, the range of beneficiaries, or the type and amount of benefit paid.[106]

Clearly, the debate about positive and negative rights appears central in litigation regarding rights to income assistance and if courts are unwilling to interpret s. 7 of the *Charter* to compel governments to provide a minimal level of subsistence, then it would be inconsistent to say that s. 7 provides a right to access specific health care services. So, from a health care advocacy perspective, the judicial rejection of claims such as *Gosselin* does not bode well for the use of s. 7 litigation to address fundamental social determinants of health.[107]

The Problem of Defining a Section 7 Right to Health Care

From a legal perspective, if the Court were to rule s. 7 protects a positive right of access to state-funded health care services, the content of that right would likely be quite difficult to define. In *Gosselin*, while Arbour J. was quite comfortable in asserting the existence of positive rights under s. 7, she recognized the difficulty in defining the scope of such rights:

> The ostensible difficulty… here is the general assertion that positive claims against the state for the provision of certain needs are not justiciable because deciding such claims would require courts to dictate to

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[106] *Ibid.* at 92.

[107] Joel Bakan also makes this point in *Just Words: Constitutional Rights and Social Wrongs* (Toronto: University of Toronto Press, 1997) at 139:

> All the proposals for a social right to health place on the state an obligation to ensure that all Canadians have access to health care. They say nothing, however, about the social determinants of ill health, particularly the unequal social relations that have much to do with why and to whom illness happens. The emphasis is on access to treatment of illness, which implies that 'the determinants of health and illness are predominantly biological, so that patterns of morbidity and mortality have little to do with the social and economic environment in which they occur.' [internal citation omitted]

> the state how it should allocate scarce resources, a role for which they are not institutionally competent.
> ...
> One can in principle answer the question of whether a *Charter* right exists – in this case, to a level of welfare sufficient to meet one's basic needs – without addressing how much expenditure by the state is necessary in order to secure that right. It is only the latter question that is, properly speaking, non-justiciable.
>
> Of course, in practice it will often be the case that merely knowing whether the right exists is of little assistance to the claimant. For, unless we also know what is required, or how much expenditure is needed, in order to safeguard the right, it will usually be difficult to know whether the right has been violated. [108]

Arbour J. purported to resolve this concern by stating "[t]his Court need not enter into the arena of determining what would satisfy such a 'basic' level of welfare because that determination has already been made by the legislature, which is itself the competent authority to make it."[109] The Québec government had established a minimum monthly welfare benefit for single adults of $466, but the claimants received less than that amount, so the case came before the Supreme Court "on the basis that the government failed to provide a level of assistance that, according to its own standards, was necessary to meet"[110] basic necessities.

Unfortunately, this attempt at resolving the problem of judicial competence to adjudicate matters of resource allocation is not particularly helpful and results in a positive right under s. 7 that may largely be devoid of clear meaning, particularly when applied in the health care context. According to the *Canada Health Act* and provincial health insurance statutes, governments will fund "medically necessary" health care services, however,

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[108] *Supra* note 38 at paras. 330, 332-333.
[109] *Ibid.* at para. 333.
[110] *Ibid.* at para. 334.

these statutes do not define what constitutes a medical necessity.[111] However, if a claimant asserts a right to health care under s. 7 of the *Charter*, the response based on Arbour J.'s reasoning is as follows: s. 7 encompasses a positive right to health care where necessary for basic protection of life and security. Courts are not institutionally competent to determine the scope of that right but Canadian governments (through the *Canada Health Act* and provincial health insurance legislation) have defined the scope as coverage for medically necessary services. So, in adjudicating a s. 7 claim, courts are merely assessing whether governments have met their own commitments to provide medically necessary health care for their citizens. However, since medical necessity is not defined, courts are right back into "[q]uestions of resource allocation [that] typically involve delicate matters of policy,"[112] matters which Arbour J. seems to say are not justiciable. The result is a frustrating degree of circularity.

Further, although in *Gosselin* Arbour J. advocates a broader interpretation of the constitutional right to life, liberty and security of the person, even her reasoning may not hold much promise for those who believe s. 7 ought to include a positive right to publicly funded health care services. Throughout her analysis, she refers to "the most basic positive protection of life and security,"[113] the "basic means of subsistence"[114] and "one's basic health."[115] In my view, this scope of positive s. 7 protection is very narrow and would apply to only a limited category of health care services. The range of services currently funded through Medicare goes well beyond those that are necessary to

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[111] I address this issue in detail in Chapter Four.
[112] *Supra* note 38 at para. 331.
[113] *Ibid.* at para. 309.
[114] *Ibid* at paras. 309 & 332.
[115] *Ibid* at para. 311.

safeguard a basic level of health. Monique Bégin, who served as federal Minister of National Health and Welfare during the drafting and enactment of the *Canada Health Act*,[116] has stated that our public health care system includes more than "a basic level of care. The words of the Canada Health Act are generally taken to imply entitlement to a complete health care system."[117]

If our health care system already ostensibly covers more than basic services, then s. 7 review that is limited to ensuring the system covers a minimal level of care will accomplish nothing for those who view *Charter* litigation as a means of expanding the scope of Medicare. For litigants in cases like *Cameron* and *Auton*, though, the system is not complete enough because it excludes funding for services they argue are basic to their needs. Is it then possible to define objective and universal criteria of what constitutes "basic" health care? Probably not. As Mary Ann Baily discusses, there is little agreement on what constitutes a minimum level of health care.[118] She begins by arguing the value of health care justifies some claim against the state to provide at least a minimum level of care:

> The benefits of health care vary in importance, from the preservation of life to the elimination of minor inconvenience, and some highly beneficial care is extremely costly. Society's resources are limited. To guarantee universal access to all care of any benefit would be prohibitively expensive, compromising the ability to spend resources on other important social goods which might even have more impact on health through, for example, better nutrition or safer transportation. It seems reasonable to conclude that society must guarantee access only to a limited level of care.

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[116] For Bégin's account of the process leading to the enactment of the *Canada Health Act*, see Monique Bégin, *Medicare: Canada's Right to Health* (Montréal: Optimum Publishing International, 1988).
[117] *Do We Care? Renewing Canada's Commitment to Health. Proceedings of the First Directions for Canadian Health Care Conference*, Margaret A. Somerville, ed. (Montréal: McGill-Queen's University Press, 1999) at 105.
[118] *Supra* note 11.

> This level is variously referred to as a "decent minimum," "basic care," or "an adequate level," with the content determined in reference to the reasons for considering health care to be "special."[119]

However, Baily notes the scope of a right to a decent minimum depends on factors such as an individual's needs and the wealth of the country in which the person resides:

> ...the adequate level of care varies with health condition. ...the importance of health care – the extent to which it is special depends on an individual's health state. Therefore, any system to define and deliver a basic level of care must be able to vary the care according to individual need; a decent minimum cannot be simply an amount of money or a fixed amount of care.
>
> The adequate level of care also varies with the availability of resources in the society. ...the benefits of health care must be weighed against costs in the light of competing uses for resources.... In tempering the definition of adequacy to available resources, the priorities and values of society's members are important in guiding the trade-offs they would make among different kinds of health benefits, and between health benefits and other social goods.[120]

So, although our health care system may be comprehensive (in the sense it covers more than strictly basic care), it does not promise an "unconstrained right to healthcare services, except within available resources."[121] This view is echoed in the Romanow Report where it is noted that comprehensiveness is "not so much...a description of existing coverage [within the Medicare system], but [is] a continuing goal."[122] Indeed, the report states that the gap between services that are covered and those that could be covered to create a more comprehensive system "exists in the first place because of the

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[119] *Ibid.* at 167.
[120] *Ibid.* at 168.
[121] Pranlal Manga, "Medicare: ethics versus economics" (1987) 136 Can. Med. Assoc. J. 113.
[122] *Supra* note 3 at 62.

impossibility of the public purse covering all health services immediately. Financial probity requires that services be added as fiscal resources permit."[123]

The task of sorting health care services into categories of "basic" and "comprehensive" is clearly complex, so arguing that a s. 7 claim to publicly funded health care is restricted to ensuring access to basic services does little to define the proper scope of *Charter* review of government policy decisions. What is one person's basic service may strike another as a comprehensive service that should only be covered after government has addressed other priorities.

Conclusion

The prospects seem dim that the Supreme Court of Canada will recognize a positive right to publicly funded health care services under s. 7 of the *Charter*. Even if the Court were to broaden the application of s. 7 in this manner, I suspect the content of the right would be so vague or so attenuated as to offer little to fulfill the hopes of those who view s. 7 litigation as a means to expand the scope of our Medicare system by challenging government decisions to restrict health care funding. Yet, while courts have been unreceptive to s. 7 claims regarding access to publicly funded health care services, they have interpreted equality rights under s. 15 right to confer a right of access to health care in some circumstances. Questions about what those circumstances might be are the topic of my next chapter.

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[123] *Ibid.* at 63.

Chapter Four: The Uncertain State of the Law Regarding Access to Health Care and Discrimination under Section 15 of the *Charter*

Introduction

Individuals or groups who feel aggrieved by a government's refusal to fund specific health care services may turn to section 15 of the *Charter* to challenge the government's decision. In such cases, the claimant argues the government has failed to fund a service that is medically necessary for him or her and this failure amounts to discrimination, usually on the basis of disability. Such claims involve the application of evolving s. 15 jurisprudence in a policy context – health care – marked by almost constant debate, often about issues of resource allocation and fiscal sustainability. As a result, these cases provide rich fodder for debate on many intersecting issues of constitutional law and health care policy.

In this chapter, I focus on two elements that bring uncertainty into s. 15 cases in which claimants seek public funding for health care services. The first element of uncertainty arises from the lack of clarity regarding the term "medically necessary," which is used in the *Canada Health Act* (the "*CHA*") and in provincial health care insurance legislation to describe the services to which Canadians are entitled through the public health care system. In essence, s. 15 litigation about access to health care begins with an argument between the claimant and the government about whether a service is medically necessary. After a court considers whether a service can be considered medically necessary for persons in the position of the claimant, the question is whether denial of public funding for that service constitutes discrimination contrary to s. 15(1) of the *Charter*.

The second element of uncertainty is found within the s. 15(1) analysis itself; namely, the focus on human dignity as the core interest protected by *Charter* equality rights. As with the concept of medical necessity, the notion of human dignity is ambiguous. While general attributes of both concepts can be articulated, precise definitions are impossible. In s. 15 challenges to government resource allocation decisions in health care, these two vague notions come into play, resulting in the difficult challenge of determining when a government's decision not to fund a particular health care service violates human dignity and therefore amounts to discrimination.

The s. 15(1) analysis involves questions that precede an examination of whether impugned governmental action infringes dignity. Before considering the impact of governmental action on human dignity, courts must first determine whether the claimant is treated differently from others and whether the differential treatment is based on a ground enumerated in s. 15(1) or an analogous ground. While acknowledging the importance of these two questions in the discrimination analysis, I focus on the dignity aspect for the primary reason that it is likely to be the most difficult to address since dignity is such a malleable notion. In many cases, though certainly not all, it may be relatively clear that a claimant is treated differently from others because of an enumerated or analogous ground. However, the challenge will arise in deciding if that differential treatment is an affront to dignity and therefore constitutes discrimination. Certainly, in the health care context, this issue is likely to be the thorniest, so it is the focus of this chapter.

I begin with a brief discussion of the value Canadians place on access to universal, publicly funded health care, which is an important contextual factor in considering when a denial of public funding for a health care service violates human dignity. Next, I examine the use of medically necessary as a term that purports to establish parameters around the health care services governments are obligated to fund and, therefore, to which patients are entitled access. I then discuss the Supreme Court of Canada's most recent effort in *Law v. Canada*[124] to synthesize a framework for analyzing discrimination claims under s. 15(1), considering especially the Court's statements about dignity as the key value underlying equality rights.

I then comment on *Cameron* and *Auton*, two cases in which claimants have used s. 15(1) to claim a right to public funding for specific health care services. In particular, I examine how the courts in these two cases analyzed the notion of what constitutes a medically necessary service and when a distinction regarding access to health care amounts to a violation of dignity. After analyzing these two cases, I consider several problematic aspects of basing s. 15(1) claims, especially in the health care context, on malleable concepts of medical necessity and human dignity. My conclusion is that current jurisprudence on the issue of discrimination and access to health care raises more questions than it answers and I hope this effort to identify questions will help frame future discussion about possible responses to those questions.

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[124] [1999] 1 S.C.R. 497 [*Law*].

The Value of Health Care and Health Care as a Value

Health care is often described as a fundamental value for Canadians and, increasingly, individuals and groups in Canada are turning to the language of rights to seek access to health care services. In s. 15(1) *Charter* cases, this is exemplified by the claim that, as a matter of equality, individuals have a right to access certain state-funded health care services. Claims to a "right" to health care services seem to stem from the value, both real and symbolic, individuals place on health care. At a symbolic level, many Canadians agree that "[u]niversal publicly funded health care is part of what it means to be a Canadian and reflects our core values."[125]

Despite the value Canadians attach to a system of publicly funded health care, it is a reality that government health care budgets are finite and choices must be made about what services will be covered and which will fall outside the boundaries of the public health care system. This challenge leads to the tricky question of delimiting the scope of public health care insurance which, in Canada, is accomplished (albeit ambiguously) by the phrase "medically necessary."

The Concept of "Medically Necessary" in the Canadian Health Care System

The structure of the health care system is set out in the *CHA*, which describes in expansive language the purpose of Canadian health policy:

> It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.[126]

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[125] Conference Board of Canada, *Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results* (Ottawa: Conference Board of Canada, 2000) at 11.
[126] *Supra* note 4, s. 3.

The *CHA* sets out five criteria the provinces must meet in order to receive a full financial contribution from the federal government for health care. These criteria are: public administration, comprehensiveness, universality, portability and accessibility.[127] The criterion of comprehensiveness is linked with medical necessity and the *CHA* states:

> In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.[128]

The *CHA* defines "insured health services" to mean "hospital services, physician services and surgical-dental services provided to insured persons...."[129] In turn, "hospital services" are defined as specific listed services that "are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability" and "physician services" are "any medically required services rendered by medical practitioners." [130] The *CHA* does not define the terms "medically necessary" or "medically required." Provincial health care insurance legislation throughout Canada also uses the phrases "medically required" or "medically necessary" to describe health care services that are publicly funded, but, as with the *CHA*, the provincial statutes offer no definition.[131]

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[127] *Ibid.*, s. 7.
[128] *Ibid.*, s. 9.
[129] *Ibid.*, s. 2.
[130] The listed hospital services include the following services provided to in- or out-patients at a hospital: accommodation and meals; nursing care; diagnostic procedures; drugs administered in the hospital; and use of medical and surgical equipment.
[131] For example, the British Columbia *Medicare Protection Act*, R.S.B.C. 1996, c. 286, insures "medically required services" (s. 1). In Alberta, the *Health Care Insurance Act*, R.S.A. 2000, c. A-20 defines "insured services" as "all services provided by physicians that are medically required..." (s. 1) Under the Ontario *Health Insurance Act*, R.S.O, 1990, c. H.6, "insured services" include "medically necessary services rendered by physicians..." (s. 11.2). The terms "medically necessary" or "medical required" are not defined.

As a result, decisions regarding what services will be covered under health care insurance legislation becomes a matter of provincial policy-making. Typically, (as I discuss in more detail in Chapter Five) these decisions have been made through negotiation between provincial health ministries and provincial medical associations.[132] In 1994, the Canadian Bar Association Task Force on Health Care[133] remarked:

> Much of the debate over medicare in Canada revolves around the definition of what services are "medically required". By not including a definition of this term in the CHA, the federal government seems to have left it up to each province and territory to establish its own definition. ...the provinces have also chosen not to provide a substantive definition, so the scope of "medically required services" and indeed, all "insured health services", is a policy decision.[134]

This statement is as true today as it was almost ten years ago.

The Canadian Bar Association Task Force and other commentators have suggested the term "medically necessary" should be explicitly defined in order to provide greater certainty and uniformity across Canada about what health care services will be publicly insured and to control health care costs.[135] Others argue this term is not amenable to

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[132] Colleen M. Flood, "The Anatomy of Medicare" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2d ed. (Markham, Ont.: Butterworths, 2002) 1 at 23. See also Colleen M. Flood, Mark Stabile and Carolyn Hughes Tuohy, "The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care" (2002) 12 Health Matrix 297 at 303.

[133] Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994).

[134] *Ibid.* at 31.

[135] For example, based on concerns about lack of clarity and predictability in what services are considered medically necessary, the Canadian Bar Association Task Force made the following recommendations (*ibid.* at 41-42):

> Each province and territory and the federal government should enact a definition of the term "medically necessary", which would apply equally to the term "medically required". Explicit criteria should be used to define this term...
> The definition of "medically necessary" should be arrived at through an open process of cooperation and negotiation among the federal and provincial governments, to achieve

precise definition and efforts to do so will inevitably be fruitless.[136] As Jeremiah Hurley and his colleagues note:

> Many systems of publicly funded health care espouse medical necessity (or a close variant such as need) as a guiding principle for allocating resources (even if not all enshrine it in legislation). Yet, logic and experience demonstrate that it is likely impossible to develop a concise, explicit, operational definition of medical necessity that could be used as an administrative tool.
> ...
> It follows that we should refrain from further efforts to develop such an operational definition of medical necessity.[137]

If the term medically necessary cannot be defined precisely, are there at least some identifiable boundaries around the services it encompasses? Even without an exact definition of the phrase, is there value in attempting to define the goals or interests that underlie the term? Hurley *et al.* seem to think so:

> Even if medical necessity cannot be defined precisely, it seems useful to explore the range and boundaries of its meanings, its essential constitutive elements, and the imperatives that follow from them, not with the intention of developing a definition, but to understand the key concepts better, to inform the policy discourse that surrounds it, and to facilitate its use in health policy as a guiding principle.[138]

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uniformity to the greatest possible extent.

In regard to the cost-saving potential of explicitly defining what constitutes medically necessary services, many commentators have argued this potential is largely empty and de-insuring health care services does not result in significant savings. See e.g. Cathy Charles *et al.*, "Medical Necessity in Canadian Health Policy: Four Meanings and...a Funeral?" (1997) 75:3 Millbank Q. 365 at 376-378.

[136] See e.g. Jeremiah Hurley *et al.*, "Medical necessity, benefit and resource allocation in health care" (1997) 2 J. Health Serv. Res. Policy 223, Timothy A. Caulfield, "Wishful Thinking: Defining "Medically Necessary" in Canada" (1996) 4 Health L.J. 63, Michael M. Rachlis, "Defining Basic Services and De-Insuring the Rest: The Wrong Diagnosis and the Wrong Prescription" (1995) 152:9 Can. Med. Assoc. J. 1401, and Glenn Griener, "Defining Medical Necessity: Challenges and Implications" (2002) 10 Health L. Rev. 6. For commentary on "medical necessity" in the U.S. context where many private health insurance contracts use the term to define the scope of coverage under the contract, see e.g. E. Haavi Morreim, "The Futility of Medical Necessity" (2001) 24 Regulation 22 and Linda A. Bergthold, "Medical necessity: Do we need it?" (1995) 14 Health Affairs 180.

[137] Hurley, *ibid.* at 223.

[138] *Ibid.*

They suggest the concept of benefit is a key element in determining what constitutes a medically necessary health care service. However, they acknowledge the difficulty in deciding what counts as a benefit and "[i]n particular, when does a benefit of a particular type and magnitude make it reasonable to draw on public resources to meet the need?"[139] In their view, assessing the benefit of a health care service can focus on an individual patient (for example, assessing whether a service improves the person's health or well-being, however those terms are defined) or on broader social benefits and costs associated with allocating funding to certain services over others.

The most skeptical (and perhaps most realistic) view is that it is extremely difficult to arrive at any consensus about the types of benefits that count in assessing whether a service is medically necessary, or even in agreeing about what health outcomes are desirable and warrant drawing on public resources. Cathy Charles and colleagues suggest

> ...attempts to achieve consensus on the meaning of medical necessity are likely to fail. Stakeholders have a vested interest in preserving their favoured meaning and advocating for its broader acceptance. Consensus regarding a definition of medical necessity is difficult to achieve precisely because its value to stakeholders lies in the ease with which it can be construed to serve multiple policy and ideological ends.
>
> ...
>
> It seems an obvious point that the meaning of necessary services depends, to a large extent, on the goals of the health care system. Yet there is no consensus in Canada on this issue.[140]

Finally, as the most recent addition to the Canadian health care policy debate, it is worth noting the Romanow Commission's commentary on the issue of medical necessity and

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[139] *Ibid.* at 224.
[140] *Supra* note 135 at 386, 388.

comprehensiveness in the health system. Romanow states that "essential health care services must be available to all Canadians on the basis of need and need alone"[141] and argues the health care system currently falls below what a truly comprehensive, publicly insured system of medically necessary care would provide:

> The current *Canada Health Act* includes the principle of comprehensiveness. However, for the last 35 years, comprehensiveness has been limited to "insured health services" defined as medically necessary hospital and physician services.... This is not how the average person would define comprehensive.
> ...
> Despite this, comprehensiveness should be retained as a principle, not so much as a description of existing coverage under the *Canada Health Act* but as a continuing goal. It should be redefined to mean that, as financial resources permit and as the health care system changes, the definition of comprehensiveness (and of services insured under provincial plans) should continue to evolve...[142]

Ultimately, we are left with the following understanding of the term medically necessary in Canadian health care policy: the term is not defined, nor is it susceptible of precise definition; individuals will advocate their preferred definition based on policy goals they seek to attain, so achieving consensus in defining the term is likely impossible; and, ultimately, an undefined notion permits the health care system to evolve. But where does this leave us when assessing claims by individuals that a government discriminates against them by not funding services they assert are medically necessary? In the context of *Charter* litigation about access to health care services, it is important to consider how an adversarial forum focused on the adjudication of individual rights and liberties shapes how litigants construct arguments of benefits, costs and desired outcomes.

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[141] *Supra* note 3 at 61.
[142] *Ibid.* at 62-63.

The Discrimination Analysis under Section 15(1) of the *Charter*

As noted earlier, individuals and groups who want access to services that are not funded by their provincial health care plan are turning to litigation under s. 15(1) of the *Charter* to attempt to compel governments to fund these services. The essence of their argument is that government discriminates against them by not funding a service they consider medically necessary.

Section 15(1) of the *Charter* provides individuals with legal protection from discrimination and states:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

In its 1989 decision in *Andrews v. Law Society of British Columbia*,[143] the Supreme Court of Canada set out the authoritative definition of discrimination in Canadian law:

> ...discrimination may be described as a distinction, whether intentional or not, but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.[144]

In *Andrews*, the Court emphasized that not every law that draws a distinction will violate s. 15(1) of the *Charter*. Indeed, the Court has emphasized governments must draw distinctions to govern effectively:

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[143] [1989] 1 S.C.R. 143 [*Andrews*].
[144] *Ibid.* at 174, McIntyre J.

> It is not every distinction or differentiation in treatment at law which will transgress the equality guarantees of s. 15 of the *Charter*. It is, of course, obvious that legislatures may – and to govern effectively – must treat different individuals and groups in different ways. Indeed, such distinctions are one of the main preoccupations of legislatures. The classifying of individuals and groups, the making of different provisions respecting such groups, the application of different rules, regulations, requirements and qualifications to different persons is necessary for the governance of modern society.[145]

The question is then: How do courts determine what distinctions amount to discrimination contrary to s. 15(1) of the *Charter*? The Supreme Court of Canada provided its most recent guidance for answering this question in its unanimous decision in *Law v. Canada*.

In *Law,* the Court set out a general framework for analyzing claims of discrimination under s. 15(1) of the *Charter*. In examining whether a law or governmental action constitutes discrimination, a court must ask itself the following questions:

> First, does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is differential treatment for the purpose of s. 15(1). Second, was the claimant subject to differential treatment on the basis of one or more of the enumerated and analogous grounds? And third, does the differential treatment discriminate in a substantive sense, bringing into play the purpose of s. 15(1) of the *Charter* in remedying such ills as prejudice, stereotyping, and historical disadvantage? The second and third inquiries are concerned with whether the differential treatment constitutes discrimination in the substantive sense intended by s. 15(1).[146]

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[145] *Ibid.* at 168.
[146] *Supra* note 124 at para. 39 [emphasis in original].

The third question asks whether the differential treatment brings into play the purpose of s. 15(1), which the Court in *Law* summarized as follows:

> It may be said that the purpose of s. 15(1) is to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration.[147]

The Court elaborated at some length on the notion of human dignity:

> What is human dignity? There can be different conceptions of what human dignity means. For the purpose of analysis under s. 15(1) of the *Charter*, however, the jurisprudence of this Court reflects a specific, albeit non-exhaustive, definition. ...the equality guarantee in s. 15(1) is concerned with the realization of personal autonomy and self-determination. Human dignity means that an individual or group feels self-respect and self-worth. It is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment premised upon personal traits or circumstances which do not relate to individual needs, capacities or merits. It is enhanced by laws which are sensitive to the needs, capacities and merits of different individuals, taking into account the context underlying their differences. Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.[148]

The Court also stated that "[h]uman dignity within the meaning of the equality guarantee... concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?"[149] Although the Court emphasized the discrimination analysis must be undertaken from the

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[147] *Ibid.* at para. 51 [emphasis added].
[148] *Ibid.* at para. 53 [emphasis added].
[149] *Ibid.*

perspective of the claimant, the claimant's subjective view must be supported by an objective assessment of her or his situation; namely, from the point of view of a reasonable person in the claimant's circumstances.[150] In addition, various "contextual factors" must be considered in determining whether governmental action demeans the claimant's dignity, including the purpose and effect of the impugned law or action, the circumstances of the person or group alleging discrimination, and the nature of the claimant's interests that are affected by the governmental action. [151]

Limitations of Human Dignity in the Discrimination Analysis

A number of academic writers have commented on the limitations of basing the discrimination analysis under s. 15(1) on the concept of human dignity. Referring to the *Law* decision, Sheilah Martin notes:

> My fear is that the Court's selection of human dignity as the main defining standard may not prove as helpful as it initially appears. Dignity is a basic value and it is hard not to be in favour of it but the first problem is one of definition. The Court notes that "no single word or phrase can fully describe the content and purpose of section 15(1)" and that is true. However, the focus on human dignity and defining rights by reference to other general concepts provides little clarity. If constitutional rights enshrine vague but meaningful generalities, human dignity suffers the defect that it is a proxy which is even less meaningful and more vague.[152]

Martin goes on to argue that "a dignity based equality standard is inherently malleable. While it may be easier to determine when human dignity is demeaned, it will be more

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[150] *Ibid.* at paras. 59-61.
[151] *Ibid.* at paras. 62-75.
[152] Sheilah Martin, "Balancing Individual Rights to Equality and Social Goals" (2001), 80 Can. Bar. Rev. 299 at 329.

difficult to articulate why it is not."[153] As I discuss below, this is precisely the major difficulty inherent in discrimination claims in the health care context.

Martin also suggests the "subjective/objective test" for assessing whether a person's dignity has been violated is another problematic aspect of the *Law* framework. She notes:

> Someone who has taken the trouble to become a complainant under section 15 will almost always meet the subjective portion of this standard. The Court will therefore be left to determine the reasonableness of that person's subjective experience of inequality. Someone whose claim is rejected under section 15 is therefore either suffering from false consciousness (subjectively) and/or else is being unreasonable (objectively). The reasonable person is a notoriously malleable construct, often invoked to put distance between decision-makers and their conclusions, but why is it needed here?[154]

Donna Greschner shares Martin's concerns about the malleability and imprecision of the notion of human dignity as the underlying purpose of s. 15(1).[155] Greschner states that one of the problems with dignity is that it "becomes an assertion, not an analysis. To ask whether a law offends 'dignity' gives precious little guidance to litigators and judges; conclusions about dignity become masks for the exercise of judicial discretion."[156] She adds that

> casting discrimination in the language of dignity is too loaded. From the claimants' perspective, they must prove that a distinction violates their dignity, which is a bit unseemly. Draping an allegation of discrimination in dignity language deeply personalizes it and brings it to the heart of an individual's sense of self-worth. This makes the allegation more emotion-laden, and thus more rhetorically powerful. But can we say convincingly that every discriminatory act involves attacks of this magnitude on the individual's sense of self-worth? Moreover, do we want to do so?

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[153] *Ibid.*
[154] *Ibid.* at 330.
[155] Donna Greschner, "Does *Law* Advance the Cause of Equality" (2001), 27 Queen's L.J. 299.
[156] *Ibid.* at para. 25.

> Dignity is indeed a feeling…but equality rights are legal rights and law is a discipline of reason and persuasion. The problem with feelings is that no one can argue against them.[157]

Peter Hogg adds another voice in criticizing the predominance of human dignity in the discrimination framework set out in *Law*:

> The element of human dignity that has now been injected into the s. 15 jurisprudence is, in my view, vague, confusing and burdensome to equality claimants. Although various "contextual factors" were listed in *Law* to assist in the task of determining whether a distinction impairs human dignity, the factors are not very helpful and the concept of human dignity is inherently vague and unpredictable in its application.[158]

As these critiques suggest, the emphasis on human dignity in the discrimination analysis will likely be problematic in many s. 15(1) claims and, in my view, concerns regarding the notion's pliability, vagueness and emotional appeal are exemplified in *Charter* claims regarding access to health care services.

Section 15(1) Claims and Access to Health Care Services

To date, Canadian courts have had several opportunities to consider s. 15(1) claims in which litigants challenged government decisions not to fund specific services in the health care context. I will focus here on two such cases, *Cameron v. Nova Scotia* and *Auton v. British Columbia*.[159]

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[157] *Ibid.*

[158] Peter W. Hogg, *Constitutional Law of Canada*, Stud.ed. (Toronto: Carswell, 2001) at 1014. Hogg argues (at 1014-1015) the dignity aspect is burdensome to claimants because they must, in essence, convince the court that the impugned distinction is unfair or unreasonable, an approach that Hogg notes the S.C.C. rejected in *Andrews*.

[159] The S.C.C. decision in *Eldridge v. British Columbia*, *infra* note 237, where several deaf individuals challenged the decision of the Province of B.C. not to cover sign language interpreter services as a benefit under the provincial health insurance plan, also involved a s. 15 discrimination claim in the health care context, however I have chosen not to address *Eldridge* here for two reasons. First, that case predates *Law* and thus the analysis in *Eldridge* does not follow the *Law* framework (clearly, though, the claimants in

Cameron v. Nova Scotia

As I mentioned in Chapter Three, *Cameron* involved an infertile couple who argued the Province of Nova Scotia discriminated against them by not funding fertility treatments, in-vitro fertilization ("IVF") and intra-cytoplasmic sperm injection ("ICSI"), that could assist infertile persons in attempting to have a biologically related child. They argued fertile people have access to publicly funded health care services, such as prenatal and childbirth care, to assist them in having children, but the infertile are denied the chance of having a child because they are denied funding for IVF and ICSI.

At trial, Kennedy C.J.S.C. concluded that while IVF and ICSI may be medically indicated for individuals with infertility,[160] this does not inevitably mean the services are medically necessary and subject to coverage by the provincial health care insurance plan. In deciding these services are not medically necessary, he noted infertile people have other options for becoming parents (such as adoption), the success rate of having a child through IVF and ICSI is low (around 15% to 20%), and there are health risks associated

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Eldridge would satisfy all elements of the *Law* analysis). More importantly, I consider *Eldridge* to be distinguishable from *Cameron* and *Auton* because the deaf claimants in *Eldridge* sought funding for a service that would allow them to have equivalent access to the health care services the government had already decided to fund; that is, they wanted meaningful access to the health system, something non-deaf people take for granted. *Cameron* and *Auton* differ because the claimants in those cases wanted the government to fund an additional health care service that was not available to anyone. This distinction can be understood by analogy to a library's obligation to offer reasonable accommodation for wheelchair users. In *Eldridge*, government funding for sign language interpreters to ensure deaf patients have meaningful access to the health care system is analogous to a library providing a ramp for patrons who use wheelchairs to enter the building. In contrast, the applicable analogy in *Cameron* and *Auton* is to an individual claiming the library must spend money to buy specific books the patron believes should be in the library.

[160] The evidence at trial was that ICSI is "medically indicated" and, indeed, the "treatment of choice" in cases involving male factor infertility, the form of infertility with which Mr. Cameron has been diagnosed, characterized by poor sperm count and quality: *Cameron* N.S.S.C., *supra* note 73 at paras. 6, 10-12.

with the procedures.[161] Ultimately, he concluded: "The desire to produce one's own child is both understandable and natural. I do though, agree, with the defendants' position that this is not a medical end and in this matter the medical procedures used to attempt to have a child, although "medically indicated" and "standard" have not been shown to me to be "medically required.""[162]

Justice Kennedy went on to consider whether the government's denial of funding for these fertility services amounted to discrimination against those with infertility and concluded it did not.[163] He accepted that the decision not to fund IVF and ISCI had a differential impact on individuals with infertility who sought access to the treatments compared to the fertile, but he stated the government's funding decision was "based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking the funding, the infertile."[164] Ultimately, he concluded that "[t]he non-funding of I.V.F. and I.C.S.I. is…based on the failure of these medical treatments to come within the criteria necessary before a medical procedure is funded."[165] So, in essence, because the government had valid reasons for determining the services were not medically necessary, the refusal to insure them did not amount to discrimination.

On appeal, the majority of the Nova Scotia Court of Appeal (Chipman J.A., Pugsley J.A. concurring) found the government's funding decision contravened the claimants' rights

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[161] *Ibid.* at paras. 95 & 96.
[162] *Ibid.* at para. 99.
[163] The trial decision predated the S.C.C.'s decision in *Law*, so the judge did not structure his analysis on the *Law* framework.
[164] *Cameron*, N.S.S.C., *supra* note 73 at para. 154.
[165] *Ibid.* at para. 155.

under s. 15(1), but the violation was justified under s. 1. The majority held that IVF and ICSI are medically necessary services for infertile individuals, the denial of which offended their dignity. In addressing the infringement of the claimants' dignity, Chipman J.A. focused largely on pre-existing disadvantages the infertile experience. Specifically, he noted infertility has been viewed historically as "an unworthy state, the object of derision, banishment and disgrace."[166] The third justice, Bateman J.A., ruled that infertility does not constitute a disability under s. 15(1) but, even if it did, the denial of funding for IVF and ICSI would not demean the claimants' dignity. As discussed further below, these two opposing views in the Court of Appeal clearly highlight some of the difficulties and ambiguities in determining when a denial of public funding for a health care service constitutes discrimination in the substantive sense contemplated under s. 15(1).

Auton v. British Columbia

In *Auton*, as mentioned in Chapter Three, the British Columbia Supreme Court and Court of Appeal considered whether the B.C. government discriminated against children with autism by not funding early intensive behavioural intervention, a therapy that can be very effective in reducing autistic behaviour in many children with the disease. The parents of several children with autism challenged the government's refusal to fund the therapy, arguing that "by failing to fund effective treatment for autism, the government has misinterpreted its legislative mandate to provide health care services."[167] Further, they

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[166] *Ibid.* at para 183.
[167] *Auton,* B.C.S.C., *supra* note 74 at para 125.

argued that lack of funding for autism therapy "neglects to take into account the disadvantaged position of autistic children and results in substantively different treatment, placing an additional burden on them"[168] that those without the disease do not face. Both the trial court and the Court of Appeal held the government discriminated against the children with autism and the denial of funding could not be justified under s. 1 of the *Charter*.

The autism intervention therapy at issue in the *Auton* case is delivered by behavioural therapists who are not health care practitioners recognized by the B.C. Medical Services Commission, thus the government argued the therapy could not be considered medically necessary. The trial judge, Allan J., rejected this argument as an overly narrow definition of medical necessity and stated that instead of defining a medically necessary service by who provides it, "a more accurate definition of medical treatment is whatever cures or ameliorates illness."[169] She added that "Canadians are entitled to expect medical treatment for their physical and mental diseases. This is so, even when a disease cannot be 'cured'."[170] Considering the needs of the children with autism and the purpose of the universal public health care system, Allan J. had no difficulty concluding the early intensive behavioural therapy at issue constituted a medically necessary service for the children with autism,[171] the denial of which violated their dignity.

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[168] *Ibid.*
[169] *Ibid.* at para. 102.
[170] *Ibid.* at para. 109.
[171] *Ibid.* at para. 102.

On appeal, Saunders J.A.[172] stated that the fact children with autism did not receive the health care service they most needed to address their disease constituted differential treatment in the s. 15(1) analysis and she rejected the government's argument that a finding of discrimination was not warranted because the "health care system does not serve all health care needs and is not designed to do so."[173] In her view, the government discriminated against the children with autism by withholding funding for a treatment that held real promise of mitigating the effects of their devastating condition. She also noted that no alternative therapy was available and the health care system funds services to address other, less serious ailments.

More Questions than Answers?

In my view, the decisions in *Cameron* and *Auton* raise more questions than they answer. In part, this may be attributed to the relative newness of *Charter* claims in which litigants seek access to specific health care services based on arguments of discrimination and equality under s. 15(1). As well, the Supreme Court's decision in *Law* is a recent synthesis of discrimination jurisprudence. Newness aside, though, it seems the real challenge in these cases stems from ambiguity and divergence in views about the notions of medical necessity, human dignity, and their interrelationship in the s. 15 context.

Before focusing on problems and questions, it is important to acknowledge one point of agreement that should be uncontroversial given its generality: not all government decisions that exclude funding for particular health care services will amount to

[172] Hall J.A. concurred. Lambert J.A. agreed s. 15(1) was violated and could not be justified under s. 1, but he dissented in part on a cross-appeal issue regarding remedy.
[173] *Auton*, B.C.C.A., *supra* note 74 at para. 46.

discrimination under s. 15(1) of the *Charter*. This statement is consistent with Justice McIntyre's comment in *Andrews* that "[i]t must be recognized at once…that every difference in treatment between individuals under the law will not necessarily result in inequality…"[174] and Justice McLachlin's caution in *Miron v. Trudel* that "calling all distinctions discrimination" would "trivialize" s. 15(1).[175]

In addition to the general statement that not every government health care funding decision will constitute discrimination, a common (though, again, general) point of law can be derived from *Cameron* and *Auton*: if a government denies funding for particular health care services without ensuring the decision does not deprive an individual or group of equal benefit of the publicly funded health system based on a ground protected under s. 15(1), then the decision may well amount to discrimination. Yet, it is unclear which denials will violate equality rights and which will not. In *Cameron*, Chipman J.A. stated that "[n]ot every person denied a procedure can successfully mount a *Charter* challenge,"[176] a point Saunders J.A. reiterated in *Auton* when she stated "[t]here is no doubt that not all refusals to treat a health care problem will be seen as discrimination."[177] Yet, the fundamental question is: How do we tell when a denial of health care discriminates and when it does not and how effectively can vague concepts of medical necessity and human dignity help us answer this question?

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[174] *Supra* note 143 at 164.
[175] [1995] 2 S.C.R. 418 at para. 131.
[176] *Cameron*, N.S.C.A., *supra* note 73 at para. 170.
[177] *Auton*, B.C.C.A., *supra* note 74 at para. 49.

What comes first, the necessity or the dignity?

A significant problem in considering the interrelationship between medical necessity and human dignity is one of circularity: is human dignity demeaned because a claimant is denied access to a medically necessary health care service or is a service medically necessary because a person's dignity will be infringed if they do not have access to that service? Put another way, what comes first, the necessity or the dignity?

In *Cameron*, the trial judge and Bateman J.A. seemed to examine the question of whether IVF and ISCI are medically necessary without factoring in the effect of a denial of funding on individuals who are infertile. The trial judge was persuaded by the fact that these treatments are just one way to address a desire to have a child and they offer little success at achieving that outcome. In contrast, Justice Chipman's view that IVF and ICSI are medically necessary was foreshadowed by his finding that infertility constitutes a disability: " I do not think it can be seriously disputed that a person unable to have a child has a physical disability. …the perpetuation of the human race has, in almost all cultures and at all times, been assigned a very high value. One's inability to participate in this great plan must, for one willing to do so, be a major and deep felt disappointment."[178] Clearly he was concerned with the impact on the claimants' dignity. He also criticized the position that IVF and ICSI are not medically necessary as "'mainstream' thinking which fails to make reasonable accommodation for the infertile."[179] According to Chipman J.A., the policy process of determining which services are medically necessary must respect the values underlying s. 15(1) of the *Charter*. However, when these values

[178] *Cameron*, N.S.C.A., *supra* note 73 at para. 145.
[179] *Ibid.* at para. 164.

are defined in such broad terms – such as "dignity" and "equality" – one can feel some sympathy for the difficult task confronting government policy makers as they try to decide what services should be funded.[180]

In *Auton*, it seems the Courts' decisions that early behavioural intervention therapy is medically necessary for children with autism was clearly linked to the fact that, without the therapy, the children were doomed to an existence largely devoid of dignity; they would likely be institutionalized, could not pursue an education or employment, and would lack skills and abilities to communicate effectively with those around them. Thus, if the likely outcome of a failure to fund a service is an undignified existence, then perhaps the service is more likely to be characterized as medically necessary. But medical necessity may be defined in other ways.

How is medical necessity defined?

As discussed earlier, the term medically necessary is susceptible of many definitions and different stakeholders[181] will characterize medical necessity to suit a desired outcome. The factors courts consider in deciding s. 15(1) cases about access to health care services will certainly impact on the meanings that will be given to the term medically necessary. The opposing views in *Cameron* about the medical necessity of IVF and ICSI

[180] The challenge of reaching consensus about what health care services ought to be publicly funded is exemplified by government efforts to delist services. In 2002, the Alberta government struck a committee to review funding for various health care services. In January 2003, the Minister of Health, Gary Mar, announced the committee could not reach agreement about what services should be excluded from public insurance. He was reported as stating, "Whether something is beneficial or not to an individual is sometimes difficult to quantify. Answers don't come in black-and-white packages. They normally come in shades of grey." See Darcy Henton "Alberta plan to delist medical services has hit snag: health minister" *Canadian Press* (8 January 2003)

[181] In *Charter* litigation, relevant "stakeholders" include claimants, respondents, interveners and judges.

demonstrate the malleability of the term. At trial, Justice Kennedy agreed with the government's argument that the definition of medically necessary services should be confined to medical means to a medical end[182] and IVF and ICSI are not medically necessary because they do not address a medical end (the underlying medical cause of the male claimant's condition of infertility), even though they may result in a non-medical end (the claimants becoming parents). While the trial judge was persuaded by the government's "medical-means-to-a-medical-end" definition, the majority of the Court of Appeal was not. Indeed, Chipman J.A. disagreed with the trial judge, largely because of a differing conception about what range of ends or outcomes may be appropriately associated with a medical need. He rejected the argument that medically necessary services are only those with so-called medical ends:

> The goal of medical treatment is surely not so narrowly defined. … Surely the end of all medical treatment is to improve the quality of life. The immediate end may or may not be medical, but this seems to me to be a distinction without much, if any, difference. Having in mind their ultimate objective, I am satisfied that IVF and ICSI are procedures that could qualify as being medically necessary.[183]

Likewise, in *Auton,* the trial judge rejected the government's attempt to limit the definition of medical necessity by reference to the type of practitioner who delivers the service.

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[182] In its factum, the government argued (quoted in *Cameron,* N.S.C.A., *supra* note 73 at para. 84): "Medically necessary" should be defined with reference to a matrix involving medical and non-medical means and ends. There are four categories in this matrix: medical means to a medical end (e.g. surgical removal of an intestinal blockage); non-medical means to a medical end (e.g. alleviation of poverty); medical means to a non-medical end (e.g. growth hormone for a boy who is expected to grow to be 5'6" so that he will grow to be 6'4" and have a better likelihood of a basketball career); and non-medical means to a non-medical end (e.g. basketball lessons for the 5'6" boy).

[183] *Cameron,* N.S.C.A., *supra* note 73 at para. 85.

A service may be considered medically necessary if it addresses a burden or disadvantage a person suffers (which may be medical or non-medical). However, in the health care context, it is arguable, as both Chipman and Bateman J.J.A. noted in *Cameron*, that almost any decision to deny funding for a health care service disadvantages the person who is denied the treatment and to anyone else in a similar position. If, as Chipman J.A. also argues, the goal of medical treatment is to improve quality of life, and health care services ought to be considered medically necessary if they further this goal, then numerous services will be considered necessary. For example, it may be argued that lack of public funding for so-called cosmetic surgery may enhance some patients' sense of dignity and worth. In a recent article, a plastic surgeon argued breast augmentation surgery should be funded through the British National Health Service.[184] He argued some women suffer "significant psychological distress due to the social stigma of having small breasts" and "while it may be true that society is overly concerned about appearances, this is not an argument that those who take the brunt of these prejudices should be used as ammunition to fight against it."[185] Since many women experience "significant improvement in emotional and social functioning, mental health and self-esteem"[186] after surgery, the service ought to be publicly funded.

In *Cameron*, Justice Chipman noted "[t]he question might be asked whether everybody requiring medical services is disabled, mentally or physically" but stated "[t]hat need not

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[184] Ben Horner, "Breast augmentation should be on the NHS: a discussion of the ethics of rationing" (2002) 84 Ann. R. Coll. Surg. Engl. 82.
[185] *Ibid.* at 82-83.
[186] *Ibid.* at 83.

and cannot be decided here."[187] This is clearly an important question that requires careful consideration in the context of s. 15(1) claims regarding access to health care. Because it is so problematic to determine when a denial of health care infringes human dignity, Chipman J.A.'s statement suggests courts may attempt to limit the scope of discrimination claims in the health care context not by reference to dignity, but by deciding that certain conditions do not constitute a disability for the purposes of *Charter* protection.

Finally, a medically necessary service may be described in relation to the goals or limitations of the health care system as a whole. This can lead to a broad or narrow definition of medical necessity, depending on what feature of the overall health system is emphasized. In *Auton,* Allan J. focused on the broad, ameliorative purpose of the health insurance legislation. In her words:

> The purpose of the legislation is relevant to a determination whether *Charter* rights have been breached. Here funding appropriate treatment for autism is entirely consistent with the ameliorative purpose of the health legislation. The [B.C.] Medical Services Plan is designed to assist people with health care needs. ...the values of the health care system are to promote health, prevention and treatment of illness and disease and to realize those values through a publicly funded health care system. Having created a universal medicare system of health benefits, the government is prohibited from conferring those benefits in a discriminatory manner.[188]

Based on this broad purpose, many services could be considered medically necessary. In contrast, Bateman J.A. emphasized the limits of the public health care system:

> Acknowledging the reality of the finite resources available for health care, treatment for every disability or dysfunction cannot be offered. It is integral to the administration of health care that choices are made among,

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[187] *Cameron,* N.S.C.A., *supra* note 73 at para. 173.
[188] *Auton,* B.C.S.C., *supra* note 74 at para. 126.

> literally, thousands of treatments and procedures - treatments that are changing and evolving rapidly. Indeed it must be determined not only for what medical conditions treatments or procedures will be funded but also which of the array of alternative procedures or treatments for the same ailment will receive funding.[189]

Interestingly, Justice Bateman considers the limits on the services the health system can fund in her s. 15 analysis, while the majority of the Nova Scotia Court of Appeal evaluated this factor in s. 1, stating that "[t]he evidence makes clear the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims."[190] In *Auton,* the B.C. Court of Appeal stated the scope of the health care system, presumably the degree of comprehensiveness the government can afford, is a matter to consider under s. 1, but the Court also indicated this issue about "the extent of the health care scheme…bears…upon the root question of discrimination."[191] Although discussion of s. 1 of the *Charter* is beyond the scope of this Chapter, the decisions in *Cameron* and *Auton* reveal that the demarcation between s. 15 and s. 1 considerations in claims regarding access to health care is, at present, quite blurred.

What benefits count?

My final question asks how the benefit associated with a health care service relates to the determination of whether the service is medically necessary or if its denial compromises dignity. In *Cameron*, public funding for IVF and ICSI would give some individuals a relatively small chance of having a child but, for two appeal court justices, this possibility

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[189] *Cameron*, N.S.C.A., *supra* note 73 at para. 268.
[190] *Ibid.* at para. 234.
[191] *Auton,* B.C.C.A., *supra* note 74 at para. 48.

of achieving a desired outcome was enough to satisfy them the service is medically necessary and a denial of funding constituted discrimination. This raises the question: Is a claimant's dignity infringed by the denial of, at most, a *chance*? On the trial judge's reasoning in *Cameron*, the denial of funding for IVF and ICSI could not be viewed so broadly to mean a denial of an opportunity to become parents because there are ways other than IVF and ICSI to achieve that goal. But, for the claimants, characterizing the denial of the service as a denial of parenthood would tug more strongly on the heartstrings of dignity. I say this not to discount the claimants' genuine feelings, but to demonstrate Donna Greschner's point that framing discrimination on a violation of dignity loads the analysis with emotion.

While the service at issue in *Cameron* seemed to offer a small chance of achieving a desired outcome, the therapy in *Auton* promised a much greater likelihood of improving the condition of children with autism. This fact clearly influenced the decisions that the service was medically necessary and its denial infringed the children's dignity. This distinction may persuade some that the majority in *Cameron* reached the wrong decision and the judicial reasoning in *Auton* was correct. However, defining medical necessity and human dignity by the degree of benefit a service may offer clearly engages questions about what benefits ought to be counted. In regard to IVF, some commentators have stated "IVF produces important benefits even when it fails to produce a baby."[192] For example, it may provide diagnostic information about reasons for a couple's infertility

[192] M. Giacomini, J. Hurley & G. Stoddart, "The many meanings of deinsuring a health service: the case of in vitro fertilization in Ontario" (2000) 50 Soc. Sci. & Med. 1485 at 1492.

and can also provide "emotional closure"[193] for couples who can be satisfied they have tried everything possible to have a child.

Further, if, as *Law* instructs, a court should approach the discrimination analysis from the perspective of the claimant - with the relevant question being "How would a reasonable person in the position of the claimant feel when confronted with the government's decision not to fund a health care service?" – then the claimant's perspective on the benefit of the service ought to be considered. So if the benefit goes beyond a medical end, and even if it offers simply a *chance* at achieving a medical or non-medical end, it is still important to the claimant. This may have the effect of broadening the notion of what constitutes a medically necessary service, at least from the perspective of government policy-makers who are likely concerned with basing funding decisions on measurable evidence, such as how many births result from fertility therapies, and how many children with autism experience improvement in specific skills after receiving behavioural intervention therapy. Although some benefits may not be amenable to empirical measurement (such as improved feelings of self-worth or a sense of emotional closure), they may still have value for a claimant and, according to *Law*, are relevant in their impact on human dignity.

However, the limitation of attempting to assess feelings from the perspective of a claimant is demonstrated in *Cameron*, where both Chipman and Bateman J.J.A. purported to do so, yet reached opposite conclusions. In his analysis, Justice Chipman asked, somewhat rhetorically:

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[193] *Ibid.*

> What would the reasonably informed and dispassionate infertile person legitimately think when confronted with inclusion of full services for pregnancy and childbirth for the fertile…and the exclusion of IVF and ICSI…? What of their human dignity? Of their self-worth? The answer becomes clear.
>
> …
>
> The impact of the denial of these procedures to the infertile perpetuates the view that they are less worthy of recognition or value. It touches their essential dignity and self-worth. I agree with the appellants that this denial sends a powerful message to the infertile.[194]

Justice Bateman reached a different conclusion, perhaps because she placed greater emphasis on the objective side of *Law*'s subjective/objective perspective:

> The appellants here say that the denial of funding for the IVF procedure demeans their dignity. From a purely subjective perspective one cannot but accept that this is so. As directed in *Law*, however, we must be satisfied that such a claim is objectively supported.
>
> …
>
> I am not satisfied that the policy of excluding funding for the IVF procedure functions by stereotype or otherwise to perpetuate the view by society that the infertile are less deserving of concern, respect or consideration than others. …it is an inevitable consequence of the administration of health care that choices are made among procedures and treatments offered.[195]

Conclusion

The concluding question I will ask is whether there is any advantage in having an inexact definition of medical necessity as the basis for our system of public health insurance and an expansive notion of dignity as the basis for constitutional protection from discrimination. My answer is yes. From a policy perspective, leaving the concept of

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[194] *Cameron,* N.S.C.A., *supra* note 73 at paras. 200, 202.
[195] *Ibid.* at paras. 277, 280.

medical necessity largely undefined is beneficial as it permits the health care system to be flexible in the services it insures and responsive to the evolving health needs and expectations of Canadians. As the Romanow Report notes, "...the last thing Canadians want is for their health care system to remain as a static entity, fixed in time and unable and unwilling to change." [196] From a legal perspective, constructing *Charter* rights to equality on a broad conception of human dignity ensures robust protection for such rights and leaves room for future evolution of s. 15 jurisprudence.

However, in the context of s. 15(1) litigation, we are presently left with considerable uncertainty regarding the important question of when a denial of funding for a health care service will amount to discrimination. Ultimately, to paraphrase Charles *et al.*,[197] the meanings of medical necessity and human dignity are not intrinsic, but depend on how litigants and courts interpret and use the concepts. "Meanings are created through an interpretive and interactive process,"[198] so, as individuals and governments continue to debate and interact about funding for health care services, and as courts continue to interpret equality rights under s. 15 of the *Charter*, perhaps some of the questions I have discussed will be addressed and resolved.

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[196] *Supra* note 3 at 60.
[197] *Supra* note 135 at 386.
[198] *Ibid.*

Chapter Five: Cost Arguments and the Principle of Judicial Deference under Section 1 of the *Charter*

Introduction

In this chapter, I consider the role of section 1 of the *Charter* in justifying government decisions not to fund particular health care services. Section 1 states:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.[199]

In many cases where a government chooses not to insure a specific therapy or service, the rationale for the exclusion will be financial.[200] Controlling health care expenditures is a significant policy concern at both federal and provincial levels of government and in its analysis of health care spending trends in Canada, the Romanow Commission found that

> Canada's spending on health care is comparable with other OECD countries...[and]...[a]ll OECD countries are facing increasing health care costs and experience suggests the wealthier the country, the more it spends on health care. ....health care is taking up an increasing proportion of provincial budgets...[and] ... the reality is that health care costs are likely to continue to increase and choices have to be made about how those costs will be managed.[201]

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[199] *Supra* note 1.

[200] Financial concerns will not always drive the decision. In some cases, governments may decline to insure a service because it is considered experimental (an argument raised in *Auton* in regard to the autism therapy), too risky (an argument raised in *Cameron* in regard to IVF and ICSI), or not sufficiently effective (an argument raised in both *Auton* and *Cameron*). In some situations, governments could attempt to justify exclusion of certain services on moral grounds. An example that comes to mind is that of some genetic testing procedures where a government might refuse to insure certain tests through the public health care system based on concerns that information from such tests will be used for odious purposes, particularly in relation to children and other vulnerable populations. Some commentators suggest an assessment of the morality of offering particular genetic tests ought to be the first step in determining whether a test should be funded through the public health care system. See e.g. Timothy A. Caulfield *et al.*, "Providing Genetic Testing Through the Private Sector: A View from Canada" (2001) ISUMA: Can. Policy Res. J. 72 and Michael M. Burgess, "Whither Morality in Genetic Testing" (2001) 9 Health L. Rev. 3.

[201] Romanow Report, *supra* note 3 at 43. Research papers commissioned for the Romanow Report identify various factors that will drive future health expenditures, including aging populations, development of expensive health technologies, and rising pharmaceutical costs. See e.g. Commission on the Future of Health Care in Canada, *Influences on the "Health Care Technology Cost-Driver" Discussion Paper No. 14* by Steve Morgan & Jeremiah Hurley (Saskatoon: Commission on the Future of Health Care in Canada,

In a 2001 report on health care costs, the Conference Board of Canada reported that "as a share of total provincial and territorial government revenues, public health care expenditures in Canada will increase from 31.1 per cent in 2000 to 42.0 per cent in 2020."[202] The report also noted that

> ...while health care is clearly a fundamental service, other sectors in society also have a legitimate claim on the public purse. With health care expenditures expected to rise over the next 20 years, governments will have a difficult balancing act in terms of collecting public revenues and then allocating them among competing social programs and other important public initiatives.[203]

Although the Supreme Court of Canada has stated "budgetary considerations cannot be used to justify a violation under s. 1",[204] it is clear that the state's ability to pay for an increasing array of health care services is a fundamental issue in *Charter* litigation seeking access to currently uninsured services. Consequently, financial considerations can and will be raised to justify breaches of *Charter* rights as governments argue they cannot afford to pay for all services to which individuals may want access. Government's corollary to this argument is that courts ought to apply s. 1 of the *Charter* in a deferential manner, recognizing the expertise and authority of democratically-elected legislators to make resource allocation decisions, especially in regard to social benefit programs such as health care.

2002). For additional data on health care spending, see e.g. Canadian Institute for Health Information, *Health Care in Canada 2003* (Ottawa: Statistics Canada, 2003), esp. ch. 5, "The Health Care Dollar." This report notes (at 66) that "In 2002, seven out of every 10 dollars spent on health care came from the public purse. In total, governments and social security programs spent just over $79 billion."

[202] Conference Board of Canada, *The Future Cost of Health Care in Canada, 2000 to 2020* by Glenn G. Brimacombe, Pedro Antunes & Jane McIntyre, eds. (Ottawa: Conference Board of Canada, 2001) at i.

[203] *Ibid.* at ii.

[204] *Schachter v. Canada*, [1992] 2 S.C.R. 679 at 709.

In this chapter, then, I will focus on two related issues as they play out in the health care context: first, the role of cost arguments in justifying *Charter* breaches; and, second, the principle of deference in regard to judicial review of government policy decisions. I begin by outlining the framework established in *R. v. Oakes*[205] for assessing whether a *Charter* breach is justified under s. 1 and then review several decisions in which the Supreme Court has commented on the role of cost considerations and deference in judicial review under the *Charter*. Next, I discuss the s. 1 arguments presented in *Eldridge*, *Cameron* and *Auton* to demonstrate how arguments about cost and deference play out in cases regarding access to health care. Finally, I comment on the challenges government respondents face in attempting to convince courts that their health care resource allocation decisions deserve deference and I argue that governments ought to have convincing cost-benefit evidence to support their decisions, as well as more transparent funding processes, to make a credible claim that a lower standard of judicial scrutiny is warranted.

The Justification Analysis

In its 1986 decision in *Oakes*, the Supreme Court of Canada set out the framework for analyzing whether a limitation on a *Charter* right is justified under s. 1. In accordance with the so-called *Oakes* test, the following questions must be addressed:

> (1) Is the objective of the law or government action based on concerns that are sufficiently pressing and substantial to warrant overriding a *Charter* right?

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[205] [1986] 1 S.C.R. 103 [*Oakes*].

(2) Is there a rational connection between the limit on the *Charter* right and the governmental objective?

(3) Does the limitation constitute a minimum impairment of the *Charter* right?

(4) Is there proportionality between the benefits of the limitation and its harmful impact?

The key challenge under s. 1 is to balance the rights of individuals with the competing interests of society as expressed through government action.[206] As Dickson C.J. stated in *Oakes*, "[i]t may become necessary to limit rights and freedoms in circumstances where their exercise would be inimical to the realization of collective goals of fundamental importance."[207] The party seeking to justify a limitation bears the onus of proof and the standard for justification is the civil burden of proof on a balance of probabilities.[208] The Supreme Court of Canada has stated that "[d]ischarge of the civil standard does not require scientific demonstration; the balance of probabilities may be established by the application of common sense to what is known, even though what is known may be deficient from a scientific point of view."[209]

In s. 1 jurisprudence to date, courts have tended to focus on the third question in the *Oakes* framework – whether a limitation constitutes a minimum impairment of a *Charter* right.[210] In many cases, courts accept that a governmental objective has a pressing and

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[206] As Joseph E. Magnet notes in *Constitutional Law of Canada*, 8th ed. (Edmonton: Juriliber, 2001) at 225, there is "a tension inherent in s. 1: the Court must strike a balance between the collective interests of the community as expressed by representative legislatures and the rights of individuals. It is not surprising that there is, so far, no quick and easy method, that flows from constitutional doctrine, to deal with this tension."

[207] *Oakes, supra* note 205 at 136.

[208] *Ibid.* at 137.

[209] *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 137 (Sopinka J.) [*RJR-MacDonald*].

[210] Hogg, *supra* note 104 at 779; see also Leon E. Trakman, William Cole-Hamilton & Sean Gatien, "*R.* v.

substantial rationale and that the impugned state action is rationally connected to that objective. Further, the answer at the minimum impairment stage tends to determine a court's analysis on the proportionality branch; if a limitation does not impair rights as little as reasonably possible, then the limit will often be found to have a disproportionately harmful impact. Since *Oakes*, the Supreme Court has intimated a relaxation of the justification standard set out in that case – particularly at the minimum impairment stage - and has emphasized the need to apply the test flexibly, contextually, and, in appropriate cases, with deference to the legislative choices of governments.[211]

In applying the *Oakes* test, the Supreme Court has drawn a distinction between government acting as a "singular antagonist of the individual whose right has been infringed"[212] (as in criminal prosecutions) and the role of government in "mediating between different groups"[213] (as it does in establishing social policy and distributing various benefits). In the latter situation, where government must strike "a balance between the claims of competing groups, the choice of means, like the choice of ends, frequently will require an assessment of conflicting scientific evidence and differing justified demands on scarce resources."[214] Resource allocation decisions in health care provide a prime example; in establishing health care policy and deciding what services to

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Oakes 1986-1997: Back to the Drawing Board" (1998) 36 Osgoode Hall L.J. 83 and Martin, *supra* note 152.

[211] Hogg, *ibid.* at 797-801. In particular, Hogg notes (at 797):

> The categorical language that Dickson C.J. employed in *Oakes* to delineate the function of the Supreme Court of Canada under s. 1 appeared to leave little room for even a narrow margin of appreciation. The only law that qualified to enter into the kingdom of validity was the law that impaired the Charter right "as little as possible" [footnote omitted]. ... Not surprisingly, the Supreme Court of Canada quickly recognized that some margin of appreciation had to mitigate the least-drastic-means-requirement.

[212] *Irwin Toy*, *supra* note 67 at 994.

[213] *Ibid.*

[214] *Ibid.* at 993.

include and exclude from public funding, governments clearly must mediate between demands of various groups.

Cost as a Defence and the Price of Deference

Despite the view that courts ought to be cautious in applying a strict justification standard to matters involving social policy and the mediation between different justified allocations of scarce resources, the Supreme Court typically has not been receptive to justification arguments based on cost, and it has repeatedly warned against courts being too deferential in reviewing government action that violates *Charter* rights. After all, as Justice Marshall Rothstein of the Federal Court of Canada observes, "A violation of a Charter right or freedom is a violation of the most important individual rights and freedoms known to Canadian law. One might think that section 1 defences would hardly ever be successful."[215] However, he goes on to state that "[w]hether or not one likes it, cost may be a relevant practical consideration in a section 1 defence of an under-inclusive social benefit program."[216]

In *Singh v. Minister of Employment and Immigration*,[217] an early *Charter* case involving a s. 7 challenge to procedures under the *Immigration Act* for determining refugee status, Justice Wilson stated that

> The question of the standards which the Court should use in applying s. 1 is, without a doubt, a question of enormous significance for the operation of the *Charter*. If too low a threshold is set, the courts run the risk of

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[215] The Honourable Marshall Rothstein, "Section 1: Justifying Breaches of Charter Rights and Freedoms" (2000) 27 Man. L.J. 171 at 172.
[216] *Ibid.* at 183.
[217] [1985] 1 S.C.R. 177 [*Singh*].

> emasculating the *Charter*. If too high a threshold is set, the courts run the risk of unjustifiably restricting government action. It is not a task to be entered upon lightly.[218]

In *Singh*, government counsel argued the Canadian process for adjudicating refugee claims was similar to the process in other Western nations and, due to caseload volume, the Immigration Appeal Board did not have sufficient resources to conduct oral hearings. Wilson J. characterized these arguments as "utilitarian" and stated

> Even if the cost of compliance with fundamental justice is a factor to which the courts would give considerable weight, I am not satisfied that the Minister has demonstrated that this cost would be prohibitive as to constitute a justification within the meaning of s. 1.[219]

Cost arguments also figured prominently in the s. 1 analysis in *Egan v. Canada*.[220] *Egan* involved a claim by a homosexual couple that the federal *Old Age Security Act* violated s. 15(1) of the *Charter* by discriminating against same-sex partners by limiting spousal allowances to opposite-sex partners.[221] This case resulted in significant divisions among members of the Court. Four justices, Lamer C.J. (as he then was), LaForest, Gonthier and Major JJ. held the legislation did not violate s. 15.[222] Sopinka J. found a violation of s. 15 but concluded the discrimination was justified under s. 1. Justices Cory, Iacobucci, L'Heureux-Dubé and McLachlin all found a s. 15 infringement that was not justifiable.[223]

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[218] *Ibid.* at 217.
[219] *Ibid.* at 218-219. Although the Court made its comment in relation to complying with principles of fundamental justice under s. 7, it would arguably apply with equal force to compliance with equality rights under s. 15.
[220] [1995], 2 S.C.R. 513 [*Egan*].
[221] Section 19 of the *Old Age Security Act*, R.S.C. 1985, c. O-9 provided spousal allowances for spouses between 60 and 65 years of age if the family income was below a certain level. Section 2 of the legislation defined spouses as being of opposite sex.
[222] Because this group of justices did not find a s. 15 violation, they did not consider s. 1 in any detail.
[223] Iacobucci and Cory JJ. prepared reasons together. L'Heureux-Dubé J. wrote her own reasons and McLachlin J. substantially agreed with the reasons of Iacobucci and Cory JJ.

The s. 1 analyses reveal divisions in the Court as to the appropriate place of financial considerations in the justification process. The government argued that the cost of extending benefits to same-sex spouses would be prohibitive, with expert evidence estimating additional expenditures of $12 - $37 million per year.[224] However, Iacobucci J. criticized this evidence as "highly speculative and statistically weak"[225] and based on "guesswork".[226] He went on to say that even assuming the cost evidence was valid, he would still find "as a question of law, that they do not justify the denial of the appellants' right to equality."[227] Further:

> The jurisprudence of this Court reveals, as a general matter, a reluctance to accord much weight to financial considerations under a s. 1 analysis. ... This is certainly the case when the financial motivations are not, as in the case at bar, supported by more persuasive arguments as to why the infringement amounts to a reasonable limit.[228]

In contrast, Sopinka J. ruled the government was justified in limiting spousal benefits to opposite-sex couples. He remarked that "government must be accorded some flexibility in extending social benefits"[229] and "[i]t is not realistic for the Court to assume that there are unlimited funds to address the needs of all. A judicial approach on this basis would tend to make a government reluctant to create any new social benefit schemes because their limits would depend on an accurate prediction of the outcome of court proceedings under s. 15(1) of the *Charter*."[230]

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[224] *Supra* note 220 at 609.
[225] *Ibid.* at 609.
[226] *Ibid.*
[227] *Ibid.*
[228] *Ibid.*
[229] *Ibid.* at 572.
[230] *Ibid.* at 573.

The question of the appropriateness of justifying rights violations with cost concerns has also arisen in cases involving breaches of human rights statutes.[231] For example, ruling on the legal duty to accommodate individuals with disabilities, the Supreme Court has stated:

> While in some circumstances excessive cost may justify a refusal to accommodate those with disabilities, one must be wary of putting too low a value on accommodating the disabled. It is all too easy to cite increased cost as a reason for refusing to accord the disabled equal treatment. ... I do not assert that cost is always irrelevant to accommodation. I do assert, however, that impressionistic evidence of increased expense will not generally suffice.[232]

However, where governments must make decisions involving allocation of scarce resources, the Supreme Court has held that some degree of judicial deference may be warranted.[233] Similarly, deference may be accorded where the government has acted to protect a vulnerable group, where it mediates among groups with competing interests,

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[231] Human rights legislation is considered quasi-constitutional (see e.g. *Zurich Insurance Co. v. Ontario (Human Rights Commission)*, [1992] 2 S.C.R. 321 at 339) and judicial commentary regarding cost considerations in the human rights context is relevant to *Charter* litigation. There are especially parallels between claims of discrimination under human right statutes and s. 15(1) of the *Charter*.

[232] *B.C. (Superintendent of Motor Vehicles) v. B.C. (Council of Human Rights)*, [1999] 3 S.C.R. 868 at para. 41 (McLachlin J.).

[233] Hogg, *supra* note 104 at 801. See also *Irwin Toy*, *supra* note 67 at 993-994. For further discussion of cases involving cost arguments, see e.g. Hogg at 789-791. For discussion of the concept judicial deference, see e.g. Martin, *supra* note 152 at 348-352 and Errol P. Mendes, "The Crucible of the Charter: Judicial Principles v. Judicial Deference in the Context of Section 1" in The Honourable Gérald-A. Beaudoin & Errol P. Mendes, eds. *The Canadian Charter of Rights and Freedoms*, 3d. ed. (Toronto: Carswell, 1996) 3-1. For recent judicial analysis of the concept of deference and the application of the *Oakes* test, see *Newfoundland (Treasury Board) v. Newfoundland Assn. of Public Employees* (2002), 221 D.L.R. (4th) 513. This case involved a claim that provincial legislation that prohibited the implementation of retroactive pay equity agreements violated s. 15 of the *Charter*. The Newfoundland Court of Appeal held the legislation violated s. 15 but was saved under s. 1. In lengthy reasons, Marshall J.A. examined the notion of deference and advocated for an additional question in the s. 1 analysis, namely, asking whether the findings under the *Oakes* framework accord with the doctrine of the separation of powers between the legislative branch of government and the judiciary. Justice Marshall noted (at 647): "...it cannot be said that s. 1 endows the judiciary with licence to stand in the shoes of the other branches of government as ultimate arbitrator of which policy choices were in the best interests of the governed. ...it would appear that the *Oakes* proportionality requirements court such a role. Accordingly, it seems that some revisitation of them is in order." The Supreme Court of Canada has granted leave to appeal in this case: see [2003] S.C.C.A. No. 45 (QL).

and where complex social science evidence is involved.[234] Greschner points out that "[l]aws regulating the health care system usually possess all four of these characteristics."[235]

While acknowledging the need for deference in some cases, the Supreme Court has also cautioned against enfeebling the judicial role:

> ...care must be taken not to extend the notion of deference too far. Deference must not be carried to the point of relieving the government of the burden which the *Charter* places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable. Parliament has its role: to choose the appropriate response to social problems within the limiting framework of the Constitution. But the courts also have a role: to determine, objectively and impartially, whether Parliament's choice falls within the limiting framework of the Constitution. The courts are no more permitted to abdicate their responsibility than is Parliament. To carry judicial deference to the point of accepting Parliament's view simply on the basis that the problem is serious and the solution difficult, would be to diminish the role of the courts in the constitutional process and to weaken the structure of rights upon which our constitution and our nation is founded.[236]

The Section 1 Analysis in the Health Care Context

In cases where courts have found a *Charter* breach stemming from a government's decision not to fund a particular health care service, the government's justification argument has typically rested on considerations of cost. That is, government respondents often argue they face competing claims on public resources (and health care is just one of many), so courts must give governments latitude to establish priorities. The government

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[234] Hogg and *Irwin Toy, ibid.*
[235] Commission on the Future of Health Care in Canada, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?: Discussion Paper No. 2* by Donna Greschner (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 14.
[236] *RJR-MacDonald, supra* note 209 at para. 136 (Sopinka J.).

raised cost arguments in *Eldridge*, *Cameron* and *Auton* and met with mixed success. In *Eldridge*, the Court of Appeal justice who considered s. 1 held it would be too expensive to fund sign language interpreters yet, on appeal, the Supreme Court of Canada rejected the cost justification. In *Cameron*, the Nova Scotia Court of Appeal accepted the government's cost argument and, in *Auton*, both the B.C. Supreme Court and Court of Appeal rejected cost as a factor that could justify withholding public funds for autism therapy.

The principle of deference also arises in the three cases, but with three different applications: in *Eldridge*, the Supreme Court declined to rule on whether a deferential approach applied, but ruled that even with deference, the funding decision was unjustifiable; in *Cameron*, the Nova Scotia Court of Appeal used deference to uphold the rights violation; and, in *Auton*, the trial and appellate courts acknowledged the need for deference in some cases, but held it was not appropriate to defer to a governmental decision that denied an essential health care service to disabled children.

Eldridge v. British Columbia

In *Eldridge*,[237] three deaf individuals challenged the decision of the Government of British Columbia not to fund sign language interpreters as an insured benefit under the B.C. Medical Services Plan. The claimants argued that without publicly funded interpreter services, they did not have equal access to the health care system as compared to non-deaf individuals. The claim was dismissed at trial and on appeal but in a

[237] (1992), 75 B.C.L.R. (2d) 68 (S.C.) [*Eldridge*, B.C.S.C.], aff'd (1995), 125 D.L.R. (4th) 323 (B.C.C.A.) [*Eldridge*, B.C.C.A.], rev'd [1997] 3 S.C.R. 624 [*Eldridge*, S.C.C.].

unanimous decision, the Supreme Court of Canada agreed with the claimants and held the government's failure to fund sign language interpreters, when necessary for effective communication in the health care context, violated the claimants' rights under s. 15(1) of the *Charter*.

In the Court of Appeal, Lambert J.A. ruled the funding decision violated s. 15(1) but was justified under s. 1.[238] He noted that the principles underlying the *Oakes* test oblige "a reconciliation between individual rights and collective social purposes."[239] His analysis of s. 1 demonstrates a clear reticence to interfere with government resource allocation decisions and his comments are worth repeating at length as they articulate candidly the daunting task of making allocation decisions in health care:

> The Medical and Health Care Services Act stops short of providing for perfect health care coverage in many ways. ... The Act does not cover services by clinical psychologists, occupational therapists, speech therapists, nutritional counselors or physiotherapists. The Act does not provide payment for artificial limbs, hearing aids, wheelchairs or other prosthetic devices.[240] The people who need all of those services are people suffering from disabilities. Yet the Legislature has not chosen to extend direct benefits to the provision of those services.
>
> There is a national debate underway at the moment about the reduction of funds to be transferred from Canada to the Provinces in the future for Health, for Welfare, and for Education. There is a debate underway in each Province about the expenditure priorities for the reduced funds. In the allocation of scarce financial resources each Province will be required to make choices about spending priorities. Will medical equipment be bought for city hospitals or for small rural hospitals? Will the health care services in remote communities or in First Nations communities be improved? Is the best form of expenditure to raise the scale of payment for doctors and other health care workers? Should improved public

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[238] Hollinrake and Cumming JJ.A. found there was no s. 15(1) violation.
[239] *Eldridge*, B.C.C.A., *supra* note 237 at para. 55.
[240] Since Lambert J.A. wrote his judgment, the *Medical and Health Care Services Act* has been renamed the *Medicare Protection Act*, R.S.B.C. 1996, c. 286, and his comments about exclusions under the former act are not necessarily accurate today.

> facilities be provided for detection of cervical cancer, prostate cancer or breast tumours?
>
> Some of the limits imposed under the Medical and Health Care Services Act and some of the financial allocation choices that I have mentioned have resulted and will result in adverse effects discrimination against people suffering from disabilities, including serious illness itself. How can we say, in those circumstances, that expenditure of scarce resources on services that remedy infringed constitutional rights under s. 15, on the one hand, are more desirable than expenditures of scarce resources on things that cure people without affecting constitutional rights, on the other. And, indeed, how can we prefer the allocation of scarce resources to services that remedy the infringed constitutional rights of one disadvantaged group over the allocation of scarce resources to services that remedy the infringed constitutional rights of a different disadvantaged group.
>
> In my opinion the kind of adverse effects discrimination which I consider has occurred in this case should be rectified, if at all, by legislative or administrative action and not by judicial action. ...I have concluded that this is a case for judicial restraint and for deference under the Constitution and under s. 1 of the Charter to legislative and administrative expertise.[241]

The Supreme Court of Canada was not so convinced and ruled the government's funding decision discriminated against deaf patients and could not be justified under s. 1. Writing for a unanimous Court, La Forest J. assumed "without deciding...that the objective of this decision – controlling health care expenditures – is 'pressing and substantial', and that this decision is rationally connected to the objective..."[242] Although he reiterated Sopinka J.'s statement in *Egan* that courts must afford governments latitude when making resource allocation decisions, La Forest J. concluded that even with a deferential approach to reviewing the government's decision, the choice to exclude funding for sign language interpretation failed the minimum impairment aspect of the *Oakes* test.[243] The

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[241] *Eldridge,* B.C.C.A., *supra* note 237 at paras. 56-59.
[242] *Eldridge* S.C.C., *ibid.* at para 84.
[243] *Ibid.* at para. 85. Although the Court canvassed arguments in support of judicial deference, it ruled (at

most persuasive factor was the relatively small magnitude of the cost, since "the estimated cost of providing sign language interpretation for the whole of British Columbia was only $150,000, or approximately 0.0025 percent of the provincial health care budget at the time."[244]

Cameron v. Nova Scotia

In *Cameron*, concern with the cost of funding the requested fertility treatments arose in both the trial and appellate decisions, though only one set of reasons (the majority on appeal) found discrimination under s. 15 and therefore addressed s. 1. At trial, Kennedy C.J.S.C. remarked that "[t]he Canadian Health Care System remains one of the best in existence, but it is not unlimited. It cannot possibly fund every medical service available and, in fact, now struggles to fund those services traditionally covered."[245] He also cautioned that "[c]ourts should take care before interfering with an elected government's allocation of limited public funds for social programs or the medical profession's determination of health priorities."[246] This view influenced Justice Kennedy's ruling that the government's funding denial did not amount to discrimination.

The majority of the Court of Appeal found a s. 15 breach and therefore had to embark on a justification analysis under s. 1. Justice Chipman characterized the objective of the governmental measure (the decision not to fund IVF and ICSI) "as being to provide the

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para. 85) that it was "unnecessary to decide whether in this 'social benefits' context, where the choice is between the needs of the general population anad those of a disadvantaged group, a deferential approach should be adopted."

[244] *Ibid.* at para. 87.

[245] *Cameron*, N.S.S.C., *supra* note 73 at paras. 166-167.

[246] *Ibid.* at para. 171.

best possible health care coverage to Nova Scotians in the context of limited financial resources."[247] The Court considered the evidence of the government's expert witness regarding the cost of insuring IVF and ICSI in Nova Scotia, noting that the expert's report estimated an annual expenditure of $1.6 million to insure the treatments, not including the cost of drugs required during the process. On cross-examination, the expert reduced this estimate in half to approximately $800,000 per year.[248] Chipman J.A. also considered the evidence of an executive director with the Nova Scotia Department of Health who testified at trial that provincial health care expenditures were increasing while the federal government was reducing transfer payments for health care, leading to increased pressure on the provincial budget.[249] Justice Chipman also identified various health care initiatives the government had decided to fund, including "new home care programs, implementation of new emergency health programs, construction of three replacement hospitals, substantial renovations to an existing hospital, and an enlargement of the cancer treatment program at the Cape Breton Regional Hospital."[250] In doing so, he highlighted the competing demands on health care resources, much like Justice Lambert in the B.C. Court of Appeal decision in *Eldridge*.

In arguing that IVF and ICSI ought to be covered, the appellants pointed out that the provincial health care insurance plan covers many expensive treatments, including organ transplants that can cost the health care system close to $100,000 per surgery.[251] Their argument suggests that a simple calculation of the total annual cost of insuring a new

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[247] *Ibid.* at para. 218.
[248] *Ibid.* at para. 227.
[249] *Ibid.* at para. 219-221.
[250] *Ibid.* at para. 223.
[251] *Ibid.* at para. 233.

service is relatively meaningless without comparing that expense with the cost of other services that are already publicly funded. The government's expert witness referred to a method of assessing the value of a health care service by calculating its cost in relation to years of life gained.[252] Thought the expert "had difficulty translating this [method] to fertility treatments because yet another life becomes part of the picture…he agreed that $145.00 a year would represent the cost of IVF and ICSI",[253] much less than the cost of providing other insured services.[254]

In regard to the cost evidence, Chipman J.A. acknowledged that "[t]he best we can do in these circumstances…is to arrive at an approximate figure for costs which I would estimate to be in the order of a million dollars annually."[255] This response indicates much more tolerance for the "guesswork" involved in estimating costs of insuring new health care services, a view that contrasts sharply with that of Iacobucci J. in *Egan*. Justice Chipman also took judicial notice that limited governmental resources "have been a major concern for some years"[256] and commented that such limits "have threatened, in the minds of most people, the very foundation of health care. It is the general perception that it will take a great deal of effort to make do with what we have."[257]

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[252] For a discussion of the strengths and weaknesses of various methods of evaluating health care services and programs, see e.g. Robert Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) esp. chapter 11, "Evaluating Health Care Programs: Efficiency, Effectiveness, and Cost".
[253] *Cameron,* N.S.C.A., *supra* note 73 at para. 232.
[254] For example, evidence before the Court indicated that cardiac artery bypass grafts cost $50,000 for year of life saved: *ibid.*
[255] *Ibid.* at para. 228.
[256] *Ibid.* at para. 218.
[257] *Ibid.*

Overall, the decision in *Cameron* seems to reveal a less exacting standard of proof on the government to present evidence regarding the cost implications of expanding public coverage for new health care services. While the judgment summarizes the cost data put into evidence by both parties, the decision does not comment on the appellants' efforts to convince the Court that it should break down the cost of providing IVF and ICSI (to a small number like $145 per patient, per year) and compare this cost with other, more expensive services that are insured. Ultimately, Chipman J.A. adopts a deferential approach in his application of the *Oakes* test:

> The evidence makes clear the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims.
> ...
> The policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second guess them, except in clear cases of failure on their part to properly balance the *Charter* rights of individuals against the overall pressing [governmental] objective...[258]

Auton v. British Columbia

In attempting to justify its decision to exclude funding for early behavioural autism intervention, the government of British Columbia relied primarily on cost arguments[259] and contended the court ought to defer to its policy-making authority. Both the trial and appellate decisions acknowledged merit in the government's position, but found the breach of the petitioners' equality rights was not justifiable under s. 1. At trial, Allan J. stated that "[t]he Crown is entitled to judicial deference in performing its difficult task of

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[258] *Ibid.* at paras. 234, 236.

[259] The government also argued the effectiveness of the autism therapy had not been established by empirical evidence, but linked this point with cost considerations by asserting it should not be required to fund an therapy whose benefit is unproven.

making policy choices and allocating scarce resources among myriad vulnerable groups"[260] however, even with little analysis of the *Oakes* framework, she held the government had not discharged its onus under s. 1. She characterized the objective of the provincial health insurance plan as two-fold: "the primary objective…is to provide universal health care… [and the other] objective… [is] to make 'judicious use' of limited health care resources."[261] Without addressing the pressing and substantial aspects of either of these objectives, or the rational connection between the funding decision and these objectives, she concluded simply that "the state's failure to accommodate the petitioners cannot be classified as a minimal impairment of their rights,"[262] nor can the government's decision "withstand the scrutiny of a proportionality analysis."[263]

The appeal court reached the same conclusion, rejecting the argument that it should be deferential on the facts of this case and ruling that the government had not justified its discriminatory funding decision. Saunders J.A. commented that government counsel

> refer to the age-old reluctance of the courts to allocate the scarce resources of the taxpayer and urge us to defer in this matter to the Crown… This concern … is not without weight. However, the principle that government monies should be allocated only by the legislature, while strong, does not always prevail when the issue is compliance with the Constitution.[264]

The Decision-Making Challenges

There is clearly much debate about the appropriate place for cost justification and judicial deference in the s. 1 analysis, particularly in *Charter* challenges regarding denials of

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[260] *Auton*, B.C.S.C., *supra* note 74 at para. 143.
[261] *Ibid.* at para. 151.
[262] *Ibid.*
[263] *Ibid.*
[264] *Auton,* B.C.C.A., *ibid.* at paras. 56-57.

public funding for health care. If a government wants to make a credible argument that courts should respect and defer to its policy and funding decisions, the government must show that its decision-making process itself justifies judicial deference. This will require convincing evidence. Although the Supreme Court has said governments will not be held to a standard of scientific proof, governments will increasingly be required to present economic, medical and social science evidence to discharge their burden of proof on the s. 1 analysis.[265] Fundamentally, from the government's perspective, the point of this evidentiary exercise will be to establish that the cost of expanding public funding for additional health care services overrides the potential benefit to be gained; or, expressed another way, the benefit to the population generally (because government can fund other, more pressing priorities) outweighs the cost to an individual whose *Charter* right is breached. As David Eddy puts it, "[i]n settings where budgets are limited, [health care funders must] determine the costs of different treatments and … make judgments about their relative 'values' – whether a treatment's net benefits are worth its costs or it is a good use of resources."[266]

Costs and Benefits

Though the phrase "cost-benefit analysis" conjures images of economists working with complicated mathematical formulae, the phrase is an apt metaphor for the challenge

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[265] Greschner, *supra* note 235 also makes this point and states (at 16) that "[t]his evidence could involve the cost-benefit analysis engaged in by policy-makers, the medical studies that were examined, and any other relevant factors that were taken into account. If governments do not adduce evidence, their likelihood of success under section 1 is greatly diminished." Greschner, along with Steven Lewis, also advocates for greater evidence-based decision-making in health care resource allocation decisions. See Donna Greschner and Steven Lewis, "Medicare in the Courts: *Auton* and Evidence-Based Decision-Making" Can. Bar Rev. [forthcoming in 2003].

[266] David M. Eddy, "The Use of Evidence and Cost Effectiveness by the Courts: How Can it Help Improve Health Care?" (2001) 26 J. Health Pol. 387 at 389.

posed by the justification process under s. 1 of the *Charter*. Hogg points out, with reference to Dworkin's "Taking Rights Seriously",[267] that

> rights are not "taken seriously" if they can be overridden simply by an appeal to the general welfare. It should not be possible to take away a right just because, on balance, the benefits to others will outweigh the cost to the right-holder. ... Section 1 of the Charter would undermine everything that follows it if it were interpreted as permitting the Court to uphold a limit on a guaranteed right whenever the benefits of the law imposing the limit outweighed the costs.[268]

Joseph Magnet argues that

> courts will not require exacting cost/benefit choices to be made in an area where social policy choices involve a large degree of guesswork. What the Court is looking for respecting s. 1 justification of social policy disputes is whether the evidence discloses that the Legislature had a reasonable basis for adopting the limiting measure. The Court will allow the Legislature a degree of latitude in appreciating the evidence.[269]

However, evidence, as well as assumptions, about costs and benefits do figure prominently in cases regarding allocation of health care resources and adversaries in *Charter* litigation often have differing conceptions of costs and benefits.

Governments tend to focus on the immediate cost impacts of funding a new service, as well as the financial liability they may face by setting a precedent for other funding requests. Individuals who seek to expand health care coverage often emphasize the wider

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[267] *Supra* note 15.
[268] Hogg, *supra* note 104 at 766.
[269] *Supra* note 206 at 228-229. Magnet refers to Morton and Brodie's study of government facta to review the type of evidence government tends to put forward in *Charter* litigation and notes that (at 228):

> While most government cases are lost at the minimal impairment stage of the s. 1 analysis, counsel for the government adduce the vast majority of their extrinsic evidence to support the pressing and substantial objective claim. ... Government success rates might improve considerably if counsel filled in the gaps Professors Morton and Brodie have pointed out with evidence of alternative regulatory regimes, costs, etc....

See F.L. Morton and Ian Brodie, "The Use of Extrinsic Evidence in Charter Litigation before the Supreme Court of Canada" (1993), 3 N.J.C.L. 1.

cost savings that may result from funding a service, as well as psychological and social costs incurred when some groups are excluded from accessing an important benefit through a program like Medicare. In *Eldridge*, for example, the government focused on the expense of a medical sign language interpretation program, and was particularly concerned with the possible long-term financial impact of requests for language interpretation services by other groups.[270] However, the Supreme Court criticized the government for its lack of evidence to substantiate this speculative concern.[271]

Looking at the issue through a different cost lens, the claimants focused on the broader medical, social and psychological costs that could result from a failure to ensure deaf patients can communicate effectively with their health care practitioners. These include the risk of misdiagnosis, failure to follow a prescribed treatment, and feelings of fear, anxiety and exclusion that deaf patients may experience when they are unable to communicate effectively regarding their health care needs.[272]

Similarly, in *Auton*, the claimants and the government viewed the question of cost and benefits from very different perspectives. While the government argued it could not afford the cost of funding autism therapy, the parents argued the government could not afford not to fund it. Without appropriate therapy, the parents argued, many children with autism are likely to "drain" public resources for their entire life by requiring state-funded income and housing assistance as adults. The trial judge accepted this reasoning, stating that "it is apparent that the costs incurred in paying for effective treatment of

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[270] *Eldridge*, B.C.S.C., *supra* note 237 at para. 22.
[271] *Eldridge*, S.C.C., *ibid.* at paras. 92 & 94.
[272] *Ibid.* at paras. 56, 57, 69.

autism may well be more than offset by the savings achieved by assisting autistic children to develop their educational and societal potential rather than dooming them to a life of isolation and institutionalization."[273] The government also contended that the lack of empirical evidence proving the effectiveness of autism therapy also justified its funding refusal, but the trial judge rejected this argument:

> ...the fact that autism can't be "cured" is no reason to withhold treatment. Often cancer cannot be cured but it is unthinkable that treatment designed to ameliorate or delay its effects would not be forthcoming. Further, the Crown's argument that behavioural therapies will not assist all autistic children to overcome their functional limitations does not justify a failure to provide those therapies to any of them.[274]

Governments also often emphasize the broader tradeoffs or opportunity costs that are involved in choosing to fund one service over another. Lambert J.A.'s comments in *Eldridge*, excerpted at length earlier,[275] clearly demonstrate the challenge in choosing among competing health funding priorities. In *Auton*, Allan J. noted that "[t]he Crown makes the irrefragable statement that its health care resources are limited and argues that the effect of funding treatment for autistic children would direct resources away from other children with special needs."[276] On appeal, the government argued further that

> a decision in favour of the petitioners will impel the necessarily complex administrative choices required to be made in the course of balancing the myriad and competing demands for health care, into the courts for decision on the allocation of scarce resources on a case by case basis, rather than on a comprehensive and systematic basis.[277]

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[273] *Auton*, B.C.S.C., *supra* note 74 at para. 147. However, after considering an economic cost-benefit analysis of the autism therapy tendered into evidence by the claimants, the trial judge opined (at para. 145) that "it is not possible to estimate accurately either the additional immediate costs of a treatment programme or the inevitable savings in the long run."

[274] *Ibid.* at para. 136.

[275] See *supra* note 241.

[276] *Auton*, B.C.S.C., *supra* note 74 at para. 145.

[277] *Auton*, B.C.C.A., *ibid.* at para. 56.

The last part of this statement – the reference to a comprehensive and systematic basis for making health care funding decisions – is significant.[278] Since courts must assess the justifiability of a governmental act that violates *Charter* rights, governments would do well to have evidence that its choice was based on a cogent analysis of costs and benefits, including immediate and long-term financial impacts, as well as broader social impacts of its funding decision. This will not be an easy challenge to meet as it takes substantial resources – time, money, people – and expertise to evaluate the growing number of health interventions and technologies and make decisions about funding coverage.[279] The challenge of evaluating new treatments and therapies is especially daunting when one considers the lack of evidence to substantiate the benefit of many currently insured services:

> ...a large proportion of health care interventions are innocent of any formal or scientific evaluation at all, not just of efficiency, but even of efficacy. It is remarkable, and may be without parallel in human activity, that so much effort and resources are devoted through public or private channels to health care whose effectiveness has not been conclusively demonstrated, at least for the purposes claimed, either in the setting of application or at all. Odd.[280]

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[278] Greschner and Lewis, *supra* note 265, make this observation.

[279] For an overview of some of the challenges associated with conducting economic evaluation and technology assessment in health care, see e.g. Morgan & Hurley, *supra* note 201 and Evans, *supra* note 252.

[280] *Evans*, *ibid.* at 267. David Eddy, *supra* note 266, provides some examples (at 396):

> New studies continually reveal that practices that were once accepted without doubt can turn out to be worthless or even harmful. We were wrong about diethylstilbestrol [DES], radical mastectomies, ... hormone replacement therapy for heart disease.... Experts from top universities with the most experience testified under oath that high-dose chemotherapy for late-stage breast cancer would produce 20 to 30 percent long-term cure rates. Randomized controlled trials later proved them wrong.

The Important Question: "Who Decides?"

The assertion that courts ought to defer to the policy choices of governments, particularly in regard to benefit programs, rests on the principle that democratically-elected legislators are in the best position to consider various options and make decisions based on their expertise and ability to respond to the needs of the public that elected them to office. Where this argument falls down in the health care context is that a full legislative process, involving opportunities for public debate, input and consultation, often is not used to make decisions about what health care services are funded.

As I discussed in Chapter Four, the *Canada Health Act* sets out a general guarantee of public coverage for medically necessary health care services, an entitlement that is confirmed by provincial health insurance statutes. However, decisions about what services to include and exclude from the Medicare basket have typically been made through negotiation between provincial health ministries and provincial medical associations. The trial decision in *Cameron* describes the process by which the Nova Scotia Department of Health and the Medical Society of Nova Scotia entered into negotiated agreements in regard to insured services for which a medical practitioner could bill the provincial health care plan.[281] As Justice Kennedy noted

> ...throughout the life of the medicare program in Nova Scotia, the introduction of new fees for insured professional services has been subject to a process of joint review and negotiation by the tariff-making authority [the Minister of Health]... and the Medical Society. No new fees can be introduced except in accordance with that procedure.[282]

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[281] *Cameron*, N.S.S.C., *supra* note 73, esp. paras. 29 – 60.

[282] *Ibid.* at para. 60. Justice Kennedy goes on to note (at para. 168) that this process, "involving as it does, the participation of the government, answerable for how it spends public funds, and the Medical Society best able to determine how limited funds should be used, is a reasonable one." However, as noted earlier, when government counsel in *Singh* argued the Immigration Appeal Board's refugee determination process

The shortcoming of a decision-making process that is largely limited to input from physicians and health ministry officials is that, as Colleen Flood notes, they "rely upon governments to sufficiently represent public values, and for physicians to bring their technical expertise to the determination of what is 'medically necessary'."[283]

Eldridge provides another example of the somewhat ad hoc and variable way in which health care funding decisions may be made. In that case, the Western Institute for the Deaf and the Hard of Hearing, an organization that provided some medical interpreting services for deaf patients in the B.C. Lower Mainland, approached the provincial government for funding in 1989 and 1990. The first request was "declined out of hand"[284] but the second request was given some consideration by Ministry of Health staff. The trial judgment notes that the executive director who initially reviewed the funding request "was sympathetic to the request because he has an understanding of many of the problems encountered by the deaf through his experience with deaf people, including his deaf nine year old daughter."[285] He recommended that the Ministry ought to fund the program but the Ministry Executive Committee decided to reject the request because "...it was felt to fund this particular request would set a precedent that might be followed up by further requests from the ethnic communities where the language barrier might also be a factor".[286] The trial decision notes that "[i]f a declined request has sufficient merit in the opinion of a Ministry of Health representative, it will be

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was reasonable and similar to processes elsewhere, his arguments were dismissed as "utilitarian".

[283] *Supra* note 132 at 23.

[284] *Eldridge*, B.S.S.C., *supra* note 237 at para. 21.

[285] *Ibid.*

[286] *Ibid.* at para. 22. This quotation comes from an internal Ministry of Health memorandum that was entered into evidence at trial.

reconsidered when the budget for the next fiscal year is being formulated"[287] but the Ministry did not reconsider the funding request for medical interpretation services. The description of this process in *Eldridge* highlights a somewhat crude method of decision-making process that appears to depend largely on chance (will the bureaucrat who initially reviews the request have sympathy because of personal experience?) and speculation (if the government approves this request, will the floodgates then open?).

The Canadian Bar Association Task Force on Health Care Reform[288] addressed concerns with the process provincial governments use to allocate funding for health care services and advocated greater room for public discussion regarding these decisions:

> The impact of provincial health care resource allocation decisions is so important for all provincial residents that it would be desirable to have public input into these decisions. Currently, these decisions are vulnerable to attack because the lack of an open and consultative process leaves the public only one option – to protest resource allocation decisions after they have been made. This can lead to public outcries which cause the government to retreat from a decision – not a desirable way to make public policy.[289]

Martha Jackman has gone so far as to suggest that principles of fundamental justice under s. 7 of the *Charter* confer a right to "participate in health policy and resource allocation decisions not only at the level of individual service delivery, but also at the broader policy-making level."[290] For example, if a patient's personal security is threatened by a government funding decision that has the effect of denying needed care, and the patient

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[287] *Ibid.*
[288] *Supra* note 133.
[289] *Ibid.* at 101 [footnote omitted].
[290] Martha Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions under Section 7 of the *Canadian Charter*" (1995/1996) 4 Health L. Rev. 3 at 7.

has had no opportunity to participate in the decision-making process, then Jackman posits that due process rights protected under s. 7 are violated. She suggests:

> In the broader policy and regulatory setting, due process requirements can be met by ensuring that generalized decisions relating to health policy and the allocation of health care resources and services are publicly discussed and debated before their implementation. ... Possible mechanisms for implementing these due process guarantees include public hearings and other forms of public consultation on such matters as the ... development of treatment criteria, the design of rationing and cost containment mechanisms ... and in relation to the listing and delisting of services under government health insurance plans.[291]

Interestingly, a recent report of an Alberta health care committee has suggested a decision-making model that purports to address some of these concerns. The Expert Advisory Panel to Review Publicly Funded Health Services,[292] a committee established by the Alberta government in May 2002, notes that "[currently], there are a number of ad hoc processes in place for making provincial decisions on which new services and treatments receive public funding"[293] and recommends a new evaluative process based on criteria of transparency, rigor, openness and timeliness.[294] Under the proposed process, a provincially-appointed board, composed of five to nine members (including those with health care expertise as well as representatives of the public), would review funding for existing and new services taking into account the following factors: safety; demonstrated benefits in treating or preventing health problems; impact of the funding decision on

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[291] *Ibid.* at 7.

[292] Alberta, Expert Advisory Panel to Review Publicly Funded Health Services, *The Burden of Proof: An Alberta Model for Assessing Publicly Funded Health Services* (Edmonton: Alberta Health and Wellness, 2003). The report describes the role of the panel as follows (at 1):

> ...to review and make recommendations on public funding for the current basket of health services and to recommend an appraisal process for reviewing new and existing health services on an ongoing basis. The objective is to ensure that Alberta's publicly funded health services remain comprehensive and sustainable for the future, and provide the best value.

[293] *Ibid.* at 4.

[294] *Ibid.* at 5.

public access to the service; ethical concerns; impact of the funding decision on the health system; availability of other health care options; and financial costs and implications.[295] This review process would involve independent assessments by individuals with expertise in health technology assessment and other relevant fields, and would include opportunities for "stakeholder participation". Although this proposed process has certain vague elements and has not been tested in practice,[296] it represents an effort to respond to a fundamental concern about the lack of transparency in decisions about health care funding. Flood argues that such a process would "be a significant improvement over the existing system where these decisions are made by provincial governments and medical associations behind closed doors."[297]

In addition, such a process would likely lend greater weight to arguments that courts ought to give deference to government resource allocation choices when reviewing such decisions in the context of a *Charter* challenge.[298] The text of s. 1 instructs that *Charter* rights may only be limited in a manner that is justifiable "in a free and democratic

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[295] *Ibid.* at 1,9.

[296] And will not have a chance to be tested because the Alberta government has rejected the Advisory Panel's recommendation to create a health service review board. In a news release, the government made a fuzzy commitment to strengthen "[e]xisting processes…to improve the rigor and timeliness of decisions on whether or not to fund new services" and, revealing obvious concern that a new board might usurp power, stated that the government (and not some board) "will retain its authority to make decisions on whether or not to fund new procedures." See Government of Alberta, News Release, "Government funding right health services now, focus on new process for funding future services' (18 July 2003). For media commentary on the government's response to the Advisory Panel's report, see Susan Ruttan "Mar rejects ideas to cut costs, raise revenues" *Edmonton Journal* (19 July 2003) A1; Graham Thomson, "Health reform? Oh no, it's status quo" *Edmonton Journal* (19 July 2003) A18; and "Gary Mar douses fire of reform," Editorial, *Edmonton Journal* (19 July 2003) A18.

[297] *Supra* note 132 at 23.

[298] See e.g. Martha Jackman, "Protecting Rights and Promoting Democracy: Judicial Review under Section 1 of the *Charter*" (1997) 34 Osgoode Hall L.J. 661, where she states (at 680): "…where it can be shown, in a rigorous and contextualized process of section 1 review, that the legislature has come to a decision to infringe a *Charter* right through a careful balancing of competing rights and concerns, a degree of deference to that decision … may be warranted."

society"; in other words, *Charter* rights may not be limited by the arbitrary exercise of government power. Lorraine Weinrib notes that "[t]he guarantee of rights as part of our supreme law would be meaningless if limits upon them could be effected by unpredictable action of officials wielding vaguely defined powers"[299] and argues that a limitation of a right is only justifiable in a free and democratic society "if, and only if, the state has utilized its democratic law-making machinery."[300] This high standard would not be met in regard to many governmental decisions about health care resource allocation. As Jackman points out in relation to the funding decision in *Eldridge*,

> there was no evidence that the decision to infringe the equality rights of the Deaf ... was in fact the product of a careful and informed legislative choice. ... Rather, the decision was made at an informal policy level, by a legislative sub-delegate within the provincial health ministry. As many commentators have pointed out, this type of delegated decisionmaking, while a pervasive feature of current Canadian government, is not subject to any significant degree of legislative oversight or control.[301]

Conclusion

While "[t]here may have been a time when it was believed that a commitment to provide the best health care available at whatever cost was all that was needed to make it a reality,"[302] that idealistic scenario no longer exists. Consequently, the challenge of determining how best to allocate scarce health care resources to ensure greatest overall benefit, while safeguarding the constitutional rights of individuals (particularly disadvantaged or vulnerable populations), will continue to preoccupy the minds of

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[299] Lorraine Eisenstat Weinrib, "The Supreme Court of Canada and Section One of the Charter" (1988) 10 Sup. Ct. L. Rev. 469 at 477.
[300] *Ibid.*
[301] *Supra* note 298 at 668-69.
[302] Rino A. Stradiotto & Jacinthe I. Boudreau, "Resource Allocation and Accountability in Health Care" (2000) 20 Health L. Can. 40 at 51.

policy-makers and judges alike. In the end, the goal is for legislators to have "reasonable room to manoeuvre"[303] to achieve their policy objectives while ensuring that individuals whose rights have truly been infringed have adequate recourse through the courts. When governments find themselves in courtrooms attempting to justify their funding decisions, they had best be prepared to present convincing evidence to support their cost arguments, as well as their appeals to the principle of deference.

[303] I borrow this phrase from LaForest J. in *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 at 795.

Chapter Six: Conclusion

In many ways, Canadian courts have only just begun to grapple with the complex questions raised by *Charter* litigation in the health care context, particularly the thorny issues involved in claims that individuals have a constitutionally-protected right to health care through a publicly funded system. As I mentioned at the beginning of this paper, such claims strike at fundamental concerns regarding the policy-making and resource allocation powers of legislators and the competence and jurisdiction of courts to review governments' decisions. So, as a concluding piece to this paper, I will comment on the phenomenon that has become known as the "judicialization" of politics.

"Judicialization" of Politics

The "judicialization" or "legalization" of politics is a process by which individuals or groups seeking policy change do so by litigating claims through the courts rather than seeking to influence government decision making.[304] In an early *Charter* case, the Supreme Court of Canada referred to the hazards of the judiciary getting into "adjudication of the merits of public policy."[305] Judges still acknowledge these concerns (since government counsel is likely to argue them strenuously), but perhaps attribute them less weight. In the *Auton* decision, for example, the B.C. Court of Appeal noted the singularity of the claim before it by stating that "[t]his case has raised, for the first time

[304] See Christopher Manfredi, "The Judicialization of Politics: Rights and Public Policy in Canada and the United States" in Keith Banting, George Hoberg & Richard Simeon, eds. *Degrees of Freedom: Canada and the United States in a Changing World* (Montreal & Kingston: McGill-Queen's University Press, 1997) at 310. Manfredi describes the judicialization of politics as the use of litigation by "organized social movements…to seek policy outputs from government" (at 310). See also Michael Mandel, *The Charter of Rights and the Legalization of Politics in Canada* (Toronto: Thompson Educational, 1994).

[305] *Reference re: s. 94(2) of the Motor Vehicle Act* (1985), 24 D.L.R. (4th) 536 at 546 (S.C.C.).

within this jurisdiction, the issue of provision of health care treatment, and … it brought before the courts the issue traditionally left to Government, allocation of public funds."[306] The Court acknowledged concerns regarding the adjudication of public policy, but held that safeguarding the equality rights of children with autism overrode the principle that "government monies should be allocated only by the legislature."[307]

Various arguments are put forward to give legitimacy to a court's role in reviewing the constitutionality of government action, which increasingly includes review of resource allocation in health care. Joel Bakan has described these arguments as falling into two general categories: truth and trust. He writes:

> The first [truth] holds that the constitution compels judges to reach legally correct answers to particular constitutional questions. Judges do not, therefore, substitute their policy choices and preferences for those of elected officials. …
>
> The second type of argument – based on trust in judges - … rejects the notion that judges can be constrained by the constitution to reach particular decisions, postulating instead that constitutional provisions are vague and general standards… Hence it openly acknowledges constitutional decisions as resting on judicial choice and discretion. … This account legitimates judicial review on the basis that judges can be trusted…[308]

Bakan also notes the deficiencies inherent in these arguments. In regard to the claim that judges are arbiters of truth, he points out that most constitutional provisions "are couched in language so general as to allow for numerous plausible meanings."[309] As to the

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[306] *Auton*, B.C.C.A., *supra* note 74 at para. 97.
[307] *Ibid.* at para. 57.
[308] *Supra* note 107 at 16.
[309] *Ibid.* at 16.

argument that judges may be trusted, Bakan contends this argument ignores the ideological biases judges may bring to their task.[310]

These notions of truth and trust in the judicial process appear in the *Charter* cases in the health care context. As I discussed in Chapter Four, claims relating to access to particular health care services generally involve a debate over whether such services may be considered medically necessary and consequently whether the state ought to fund them. Arguments to justify the courts making such decisions invoke a belief that judges have the right answer about what constitutes a medical necessity or that we ought to trust judges to use their discretion wisely in adjudicating such claims. Neither justification for legitimizing judicial review in the health care context is particularly satisfactory. John Richards' observation, which I cited in Chapter Two, is worth repeating:

> ...constructing and running generous social programs [of which our health care system is one] require political agreement among citizens to pay large taxes, and require politicians to deliver administratively complex services. Courts cannot oblige people to pay taxes, and cannot administer complex organizations.[311]

Justice Rothstein addresses a related point when he comments on the role of courts in assessing what level of financial cost can justify a violation of a *Charter* right:

> In assessing the financial implications, significant subjectivity creeps into the court's ... analysis. ... Thus, a line-drawing exercise is commenced. ... The troubling point is that the level of cost that would or would not meet the minimal impairment test is left to the court, and in this inevitable line-drawing exercise, the subjective views of judges will be a determining factor.[312]

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[310] *Ibid.* at ch. 7. Bakan writes (at 104):

> Assuming (correctly, I think) that most judges sincerely try to apply laws fairly, and do not intend to favour one person, group, or view over another, their unconscious premises and beliefs about what is right, just, normal and natural still influence their decisions. Judicial decision making is, for this reason, best understood as an ideological process..."

[311] *Supra* note 18.

[312] *Supra* note 215 at 179, 180.

Linked with the issue of "judicializing" politics is its inexorable emphasis on rights discourse. Paradoxically, for those who value our system of health care, the assertion of rights claims to obtain access to particular services may actually dilute the scope of the system and the services it provides. The health care services available to the majority of Canadians would certainly exceed what could be described as a minimal level of services. As courts grant remedies in *Charter* cases that have the effect of directing how government must spend money on health care, governments may contemplate reducing overall benefit levels.[313]

In a similar vein, Christopher Manfredi and Antonia Maioni argue that "rights discourse narrows the range of feasible policy alternatives,"[314] particularly in the health care policy context. This concern relates back to the Crown's submission in the *Auton* case that a ruling in favour of the claimants would "constitutionalize" certain health care treatments and, consequently, restrict the policy options that might otherwise be considered.[315]

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[313] As Bakan notes, *supra* note 107, the aftermath of the Supreme Court of Canada decisions in *Tetrault-Gadoury v. Canada (Employment and Immigration)*, [1991] 2 S.C.R. 22 and *Schacter v. Canada*, *supra* note 204, provide an example of governments restricting benefits levels to address a successful *Charter* claim. These cases required the federal government to extend unemployment insurance benefits to certain groups who had previously been ineligible. However, Bakan notes (at 59) that, to comply with the Court's ruling, the federal government

> raised revenue for these extensions by increasing the number of weeks that a person must work before being eligible for UI benefits, reducing the number of weeks a person can receive benefits, and stiffen[ed] penalties for workers who quit without just cause or refused to take suitable jobs or are fired for misconduct.

[314] Christopher P. Manfredi & Antonia Maioni, "Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada" (2002) 27 J. Health Pol. 213 at 215.

[315] *Auton*, B.C.S.C., *supra* note 74 at para. 149.

Advancing rights claims under the *Charter* "narrow[s] the scope of policy discussion by equating legally enforceable rights with a single, 'correct' policy choice."[316]

Because the nature of rights-based litigation requires courts to identify "winners and losers"[317] in each particular case, the outcome of the case constrains subsequent policy-making. In the result,

> ...rights-based claims allow stakeholders in the system to redistribute significant public resources through a process outside the ordinary arena of political conflict where alternative views about resource allocation must be considered. Rights-based claims present courts with a choice between an allegedly rights-deficient allocation and a new, constitutionally mandated policy regime consistent with a claimant's own interests.[318]

The "ordinary arena of political conflict" is not wholly dysfunctional in that public pressure for health policy change can and does occur and elected decision-makers recognize the importance Canadians place on health care. The policy changes taking shape as a result of the recent recommendations of the Romanow Commission, as well as Senator Kirby's health care committee,[319] demonstrate governments are influenced to expand health care benefits in response to public pressure. The federal and provincial governments have agreed to develop a national home care program and a catastrophic drug program.[320] Various provinces are also taking steps to reduce waiting lists to ensure

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[316] *Supra* note 314 at 218.
[317] In this context, I borrow the phrase "winners and losers" from Gerard F. Anderson, "The Courts and Health Policy: Strengths and Limitations" (1992) 11 Health Affairs 95 at 98.
[318] Manfredi & Maioni, *supra* note 314 at 222.
[319] Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role* (Ottawa: The Senate, 2002) (Chair: Michael J.L. Kirby) [Kirby Report].
[320] See First Ministers' Meeting, *2003 First Ministers' Accord on Health Care Renewal*, Doc. 800-039 (Ottawa: 5 February 2003), online: Canadian Intergovernmental Conference Secretariat, Conference Information <http://www.scics.gc.ca/pdf/800039004_e.pdf>.

more timely access to surgical and diagnostic services,[321] another issue that figured prominently in both the Romanow and Kirby reports.[322]

Yet, the problem remains that the needs of some groups may not be addressed by government health care initiatives. The fact that a person with HIV may soon receive financial assistance to cover the cost of expensive drug cocktails (as part of a catastrophic drug program), or that a person who takes time off work to care for a dying family member at home may be eligible for employment insurance benefits (as part of a home care program), does not address the need of a child with autism. So, it seems inevitable that certain groups may feel they have little recourse but to challenge government health care funding decisions through *Charter* litigation.

What the Future Holds

Within the next year, the Supreme Court of Canada will hear appeals in two cases that will undoubtedly have a tremendous impact on health care policy and *Charter*

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[321] Some provinces have established wait list registries to allow patients to access information about waiting times by type of surgery, by hospital and by physician. See e.g. Government of British Columbia, Ministry of Health Services, online: <http://www.healthservices.gov.bc.ca/waitlist> and Government of Saskatchewan, Surgical Care Network, online: <http://www.sasksurgery.ca/wait-list-info.html>. Other provinces have committed to reduce waiting times. The Québec Liberal Party, which won the provincial election in April 2003, has released a health care plan that commits to target funding to reduce waiting times and establish a wait list registry: See Liberal Party of Québec, "Partners for Health: Providing Quality Health Care Throughout Québec at all Times" (February 2003), online: <http://www.plq.org/tousDocuments/santeA.pdf>. In March 2003, the Government of Nova Scotia announced it would spend $5 million over the coming year specifically to reduce wait times for cardiac tests and surgeries and $45 million would be allocated over the next three years to purchase additional diagnostic and surgical equipment to reduce wait periods. See Nova Scotia Department of Health, News Release, "Plan for Better Health Care Released" (20 March 2003) and Nova Scotia Department of Health, *Your Health Matters*, online: <http://www.gov.ns.ca/health/downloads/your_health_matters.pdf>.

[322] Romanow Report, *supra* note 3, esp. ch. 6 "Improving Access, Ensuring Quality"and Kirby Report, *supra* note 319, esp. ch. 6 "The Health Care Guarantee". I have summarized key aspects of the Romanow and Kirby Reports elsewhere: Nola M. Ries "Life Support for Health Care in Canada" (2003) 27 LawNow 9.

jurisprudence: *Auton* and *Chaoulli v. Québec*.[323] With *Auton*, the Court will have its first opportunity since *Eldridge* to address the application of the *Charter* in regard to access to publicly funded health care services. As I noted in Chapter Four,[324] there is an important difference between the claims in these two cases. In *Eldridge*, the claimants did not seek funding for a specific health care therapy to treat their disability; rather, they sought access to a service that would enable them to have equal access to health care services available to non-deaf patients. In contrast, the claimants in *Auton* argue the state has an obligation to fund a therapy to treat their disability. Consequently, a key issue for the Supreme Court to address is the extent of a government's obligation to "fund services which are directed at the amelioration of a disadvantage not created by law."[325] Greschner and Lewis also identify the importance of this question:

> ...there must be a careful analysis of whether adverse consequences arise from genuine discrimination against certain classes of persons denied benefits that could reasonably be delivered, or from unfortunate variations in the capacity of scientific knowledge to meet people's needs. Nature and the state of science may conspire to disadvantage certain groups with respect to ameliorating their conditions...[326]

The Court's analysis of the *Law* framework to the facts in *Auton* will also be significant and may address some of the questions I raised in Chapter Four of this paper.

The Court's reaction to the claim in *Chaoulli* has the potential to change the very structure under which health care is delivered in Canada. In that case, Dr. Chaoulli, a physician, and his patient, George Zéliotis, challenge the provisions of Québec's health

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[323] [2000] J.Q. no. 479 (C.S.Q.) (QL), aff'd [2002] J.Q. no. 759 (Q.C.A.) (QL), leave to appeal to S.C.C. granted, [2002] C.S.C.R. no. 280 (QL) [*Chaoulli*].
[324] See *supra* note 159.
[325] The Supreme Court of Canada's Bulletin of Proceedings uses this phrase to describe one of the issues raised in the application for leave to appeal: see [2002] S.C.C.A. No. 510 (QL).
[326] *Supra* note 265.

care and hospital insurance legislation that prohibits physicians from delivering private care in publicly funded hospitals and also prevents patients from purchasing insurance privately to pay for health care services otherwise covered through the public system. Mr. Zéliotis waited for almost a year for hip replacement surgery and argues he would have purchased the surgery privately had he not been prohibited from doing so and asserts the prohibition violates his rights to liberty and security of the person under s. 7 of the *Charter*. The cases I addressed in Chapter Three of this paper concerned s. 7 claims regarding access to publicly funded health care, but *Chaoulli* falls on the other end of the spectrum by using the *Charter* to claim a right to purchase health care privately.[327]

In a month-long hearing that involved testimony from numerous expert witnesses, the claimants in *Chaoulli* sought, in effect, a ruling that would permit the creation of a second tier of private health care insurance and delivery in Canada. In response, the governments of Canada and Québec called experts in health economics and policy to describe the adverse effect such a ruling would have on the accessibility and cost of health care. At trial, Madam Justice Piché ruled the prohibition against private insurance constituted a violation of the claimant's rights under section 7 of the *Charter*. She posed the question whether, in Canada, the right to obtain health care is a fundamental right protected under s. 7 of the *Charter*. Her response was affirmative: "If access to the health care system is not possible, it is illusory to think rights to life and security are

[327] Because of this distinction, I view *Chaoulli* as being largely outside the scope of this paper since I have been concerned with *Charter* claims in which individuals seek access to specific, publicly funded health care services. However, because of the potential significance of the Supreme Court's ruling in *Chaoulli*, I have chosen to discuss the case briefly.

respected."[328] Piché J. concluded that the restrictions on private health care in the circumstances of the case before her violated s. 7, but the infringement accorded with principles of fundamental justice.

In reaching this conclusion, Piché J. stated that the purpose of the provincial health care and hospital insurance legislation is to create a system of health care that is equally available to all individuals in Québec regardless of ability to pay. She also cited the extensive evidence led during the trial describing the likelihood that a second tier of private health care would increase waiting times for services and drive up total health costs. Ultimately, she stated the government was justified in adopting a legislative scheme that benefited the overall population even if such a scheme limited the freedom of some individuals.[329] The Court noted that those whose freedom to buy private health care was abridged were likely individuals with the wealth to do so. At the outset of her decision, Piché J. quoted the following statement of Mr. Zéliotis' counsel: "I argue for the right of wealthier individuals to have access to a parallel system of health care services."[330]

The Québec Court of Appeal dismissed the *Chaoulli* appeal but the three appeal justices gave different reasons for their decisions. With respect to s. 7 of the *Charter*, Delisle J.A. held that the interests involved in the claim amounted to economic rights (namely, the

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[328] *Supra* note 38 at para 223 [translated by author].

[329] *Ibid.* at paras. 262, 263, where she states:

> The evidence has shown that the right to access a parallel private system of health care, which the claimants seek, would have repercussions on the rights of the rest of the population. … The establishment of a parallel private health care system would jeopardize the integrity, proper functioning and viability of the public system. The [impugned legislative provisions] protect against this consequence and guarantee the existence of a quality system of public health care in Québec. [translated by author]

[330] *Ibid.* at para. 8 [translated by author].

right to enter into a private contract of health insurance) that are not protected by the constitutional rights to life, liberty and security of the person. In contrast, Forget J.A. agreed with the trial judge's reasoning regarding s. 7. Finally, Brossard J.A. suggested s. 7 would have application in the circumstances of the case, but declined to opine definitively on this issue since he agreed the appeal ought to be dismissed.

Academic commentators have also suggested s. 7 of the *Charter* may be used to challenge provincial health insurance statutes in Canada that prevent individuals from seeking health care privately, where those individuals are unable to access care within the public system because of lengthy wait lists. Stanley Hartt and Patrick Monahan have recently argued:

> ...where the publicly funded health care system fails to deliver timely access to medically necessary care, governments act unlawfully in prohibiting Canadians from using their own resources to purchase those services privately in their own country. In these circumstances, the restrictions on private payment and private health insurance that are found in the laws of the various provinces force Canadians into a system that, at a minimum, compromises their health and potentially may endanger their lives. This form of conscription engages the values protected by the Charter, particularly the right to "life, liberty and security of the person" guaranteed by section 7.[331]

As this passage indicates, the authors do not take the position that the *Charter* "guarantees a *generalized* right to purchase medical services privately";[332] rather, their argument is premised on the existence of barriers to timely treatment within the public system of health care delivery.

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[331] Stanley H. Hartt & Patrick Monahan, *The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians* (Toronto: C.D. Howe Institute, 2002). See also Andrea Karr, "Section 7 of the Charter: Remedy for Canada's Health Care Crisis?" (2000) 58 Advocate (B.C.) 3 & 4 at 363 & 531 and Marco Laverdiere, "Le cadre juridique canadien et québécois relative au développement parallele de services privés de santé et l'article 7 de la Charte canadienne des droits et libertés" (1998-1999) 29 R.D.U.S. 117.

[332] *Ibid.* at 3 [emphasis in original].

Without doubt, the outcomes of *Auton* and *Chaoulli* in the Supreme Court of Canada will have important legal and policy ramifications for our health care system. The Court will have an opportunity to address many complex questions I have raised in this paper regarding the scope of rights protected under ss. 7 and 15 of the *Charter* as well as the proper roles of legislators and adjudicators within our constitutional democracy. In regard to the health care context, Jamie Cameron describes these fundamental questions as follows:

> Should law be concerned with policy, and does law cause more problems than it solves? Should the law take a leading role in questions of health policy or should it follow?
> ...
> At some point we are going to have to decide where the law's jurisdiction ends and pure politics begins.... At stake here is nothing less than fundamental choices about who has the responsibility and the authority to make decisions about health care policy. ...should [we] have more or less law in health care policy, and [should]...the law...lead policy-makers or follow them.[333]

Although it is unlikely the Supreme Court of Canada will resolve all these questions in their adjudication of *Auton* and *Chaoulli*, we can hope they rise to the challenge of clarifying at least some of them. As Greschner and Lewis state, "Publicly funded health care as a basic entitlement of Canadians – let alone as a right – deserves no less."[334]

Conclusion

As I stated at the outset, this paper has been concerned with the application of the *Charter* in the context of legal claims in which litigants assert a right to access specific health care services within a publicly funded system of Medicare. Within each Chapter, I

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[333] Jamie Cameron, "Moving Beyond Reactive Law" in Somerville, *supra* note 117 at 148, 150.
[334] *Supra* note 265.

have focused on specific issues, identified unresolved questions, and articulated conclusions that can be drawn from the jurisprudence to date. In my examination of sections 7 and 15 of the *Charter*, I have considered two very different types of claims that litigants may use to assert a right of access to publicly funded health care services. In a s. 7 claim, individuals assert that the state has a positive, legal obligation to ensure conditions in which they may enjoy rights to life, liberty and security of the person. In the health care context, this argument translates into a claim that the state must provide funding for health care services. As I discussed in Chapter Three, Canadian courts have not been sympathetic to the claim that s. 7 guarantees access to social benefits such as income assistance and health care. Although judicial interpretation of the scope of s. 7 has broadened over the lifetime of the *Charter*, even the most generous reading limits the state's obligation to ensuring a basic level of security for its citizens. In the health care context, I argue that this caveat amounts to a significant limit on the value of s. 7 litigation as a tool to expand the scope of our Medicare system.

In contrast, it appears s. 15 claims may prove to be the means by which individuals will successfully use legal pressure to influence health care resource allocation decisions in Canada. If the government chooses to establish a health care insurance system defined by a fundamental principle of comprehensiveness, some individuals may argue that the government's decision to exclude specific services from public funding denies them equal benefit of the system. Where an individual can demonstrate this exclusion has the effect of exacerbating an existing condition of disadvantage (which, in the health care context, will often be associated with a physical or mental disability), a successful claim

of discrimination contrary to s. 15 of the *Charter* may be established. However, the imprecision of notions of medical necessity and human dignity bring some unpredictability into the outcome of particular cases. Although it is unlikely (and, from a health policy perspective, undesirable) that courts will attempt to define explicit criteria for determining when a service is or is not medically necessary, the continuing elucidation of the discrimination framework under s. 15 may bring greater certainty into determining when a denial of public funding for a health care service infringes equality rights and when it does not.

If a litigant succeeds with a claim under s. 7 or s. 15 regarding access to publicly funded health care, the state will then bear the onus of justifying its choice to limit health care funding in a manner that violates constitutionally protected rights. Arguments and analysis under s. 1 of the *Charter* have a crucial role in deciding vital questions about whether government decisions and policy objectives that limit the rights of some may nonetheless be justified. As I discussed in Chapter Five, concern with controlling health care costs will oblige courts to evaluate the strength and persuasiveness of government arguments that it cannot afford to fund every possible treatment or therapy that may benefit some individuals. In turn, this requires that governments present convincing evidence to support their claims that services are too costly or that any expected benefit is simply not sufficient to justify drawing on scarce public resources. As guesswork and speculation are not enough to meet a stringent justification test under s. 1 of the *Charter*, governments ought to give greater consideration to methods for improving the evidentiary rigor and transparency of their health policy decision-making processes.

Although political attention to health care issues waxes and wanes, concerns about access to health care services are never far from public consciousness. If individuals can obtain needed care in a timely manner, and cost is not a barrier to access, there is no incentive to bring legal challenges to the adequacy of our Medicare system. However, when the public system does not insure certain services, particularly new treatments and therapies, and access is only available to those who can afford to purchase such services privately, some individuals may be motivated to use the *Charter* to contest the government's allocation choices. The cases I have focused on in this paper clearly provide precedent for future *Charter* claims seeking access to publicly funded health care services and the pending appeals in *Auton* and *Chaoulli* will provide our highest court with an opportunity to provide important guidance regarding the application of the *Charter* in the context of our health care system.